

IN THE UNITED STATES DISTRICT COURT  
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA  
AT CHARLESTON

	x	
	:	
THE CITY OF HUNTINGTON,	:	Civil Action
	:	
Plaintiff,	:	No. 3:17-cv-01362
	:	
v.	:	
	:	
AMERISOURCEBERGEN DRUG	:	
CORPORATION, et al.,	:	
	:	
Defendants.	:	

	x	
	:	
CABELL COUNTY COMMISSION,	:	Civil Action
	:	
Plaintiff,	:	No. 3:17-cv-01665
	:	
v.	:	
	:	
AMERISOURCEBERGEN DRUG	:	
CORPORATION, et al.,	:	
	:	
Defendants.	:	

BENCH TRIAL - VOLUME 40  
BEFORE THE HONORABLE DAVID A. FABER, SENIOR STATUS JUDGE  
UNITED STATES DISTRICT COURT  
IN CHARLESTON, WEST VIRGINIA

JULY 28, 2021

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1 PROCEEDINGS had before The Honorable David A.  
2 Faber, Senior Status Judge, United States District  
3 Court, Southern District of West Virginia, in  
4 Charleston, West Virginia, on July 28, 2021, at 9:00  
5 a.m., as follows:

6 THE COURT: Good morning.

7 You may go forward, Ms. Mainigi, when you're ready.

8 MS. MAINIGI: Thank you, Your Honor.

9 Your Honor, the plaintiffs put on a long case, but they  
10 spent a long time on issues that were not in dispute.

11 Most of their witnesses talked about whether Cabell  
12 County and Huntington have experienced an opioid epidemic.  
13 But all three defendants told Your Honor from day one that  
14 we're not disputing the opioid problem.

15 The question, rather, is whether the defendants engaged  
16 in unreasonable conduct that caused harm in Cabell and  
17 Huntington.

18 And over 32 trial days, the Court heard very little  
19 about Cardinal Health's conduct. Now, not counting the  
20 McKesson and ABDC witnesses, plaintiffs called a total of 26  
21 live witnesses. Thirteen of them, Your Honor, were fact  
22 witnesses. Ten of those witnesses testified only about the  
23 use of opioids or harms from drug addiction. None of those  
24 10 said a word about Cardinal Health.

25 The only live three fact witnesses that -- the only

1 three live fact witnesses that talked about Cardinal  
2 Health's conduct were Mr. Rannazzisi, Michael Mone, and  
3 Jesse Kave. We will cover Mr. Rannazzisi's testimony in  
4 detail later. But he acknowledged that he doesn't know  
5 anything about Cardinal Health since 2012.

6 And the testimony from Mr. Mone and Mr. Kave, the two  
7 former Cardinal Health employees who testified, shows why  
8 Cardinal Health's conduct was reasonable.

9 Now, Your Honor, there were also 13 expert witnesses.  
10 And 10 of them also offered no opinions on Cardinal Health.

11 The three experts that did talk about us are the three  
12 that you see lit up below.

13 Jakki Mohr said we engaged in marketing. But she  
14 didn't say any of our marketing was false or misleading or  
15 improper in any way, or that we did anything wrong or caused  
16 any harm.

17 Dr. McCann, as you know, just calculated what was  
18 distributed into Cabell and Huntington and compared it to  
19 other places. He did not evaluate our conduct.

20 And then, of course, you've heard a lot about Mr.  
21 Rafalski. I'll come back to him. But, essentially, he had  
22 nothing to offer but *ipse dixit* conclusions without any  
23 meaningful review of our systems or our procedures.

24 Now, plaintiffs during this entire trial did not  
25 identify a single actual order that was suspicious that we



1 shipped to a customer in Cabell or Huntington. They gave  
2 the Court no specific evidence of our conduct to support a  
3 liability finding.

4 And to the extent that they focused on us at all, Your  
5 Honor, it was about the overall volume of the prescription  
6 opioid orders that we shipped. But volume does not equal  
7 wrongdoing.

8 The evidence was overwhelming and uncontroverted. What  
9 caused the increase in volume was the change in the standard  
10 of care. When the standard of care changed, doctors  
11 prescribed more opioids to treat pain. And the evidence  
12 shows that they wrote those prescriptions in good faith.

13 Mr. Rannazzisi testified that 99 percent of doctors  
14 were perfect. And that's why the DEA increased the opioid  
15 production quota year after year after year. It decided the  
16 increases were necessary to meet legitimate medical needs.

17 Now, Mr. Rannazzisi also told us he couldn't cut the  
18 quota arbitrarily even if he thought some people were  
19 abusing opioids because legitimate patients would be denied  
20 their medication.

21 But that's what the plaintiffs are saying we should  
22 have done. They're coming here and saying that we should  
23 have second-guessed the doctors and arbitrarily cut orders.

24 When you take Mr. Rafalski's now famous 90 percent  
25 flagging number and you marry it up with the testimony that

1 99 percent of doctors are perfect, those two just cannot  
2 come together, Your Honor.

3 Now, Ms. Kearse when she spoke yesterday, she spoke in  
4 terms of over-supply. And I think you asked her a question  
5 about that.

6 On that issue, Mr. Rannazzisi himself admitted that  
7 supply does not drive demand.

8 THE COURT: There are economists that disagree  
9 with that.

10 MS. MAINIGI: Excuse me, Your Honor?

11 THE COURT: There are economists that would  
12 disagree with that.

13 MS. MAINIGI: There are economists that would  
14 disagree with that. But Mr. Rannazzisi was on the ground  
15 and was increasing the quota year after year. And he  
16 testified supply does not drive demand, which I think is a  
17 critical, critical point here.

18 And I think as Your Honor knows from having sat  
19 through, very carefully through this trial, our view is that  
20 the prescribing drives the demand. And that demand is what  
21 drives the supply. And that determines the volume.

22 And as I said in the opening, Your Honor, distributors  
23 are a mirror of what's happening in healthcare. We reflect  
24 it. We don't drive it.

25 Now, plaintiffs did not just fail to put on evidence of

1 our conduct. They ignored, in our view, the question of  
2 causation.

3 At the end of this trial, there is no proof of a causal  
4 link between Cardinal Health's conduct and the harms in  
5 Cabell and Huntington. All we have are Mr. Rafalski's  
6 totally unsupported claims. No one has tried to tie our  
7 conduct to causing harm.

8 And no witness, even Mr. Rafalski, no witness has  
9 accounted for the intermediate steps in the causal chain;  
10 doctors prescribing, pharmacies dispensing, patients  
11 diverting, and users misusing. That wasn't discussed  
12 yesterday or during trial. And there's no witness that has  
13 given the Court a basis to find that we were a direct cause.

14 So we're left with the failure of proof on every  
15 dimension of plaintiffs' claim. None of the evidence shows  
16 Cardinal Health's conduct was unreasonable. None of it  
17 proves causation.

18 And on abatement, Your Honor, the relief that the  
19 plaintiffs seek, it's not abatement. It's not tethered to  
20 the actual needs of Cabell and Huntington. And it's not  
21 tied to our conduct.

22 And this chart, Your Honor, will serve as a roadmap for  
23 the issues that I intend to cover and the evidence that I  
24 intend to bring to your attention.

25 So let me start with reasonableness.

1 I think where we're at, Your Honor, is that everyone  
2 agrees that plaintiffs must prove that our conduct was  
3 unreasonable. So if the Court finds ultimately that our  
4 conduct was reasonable, there is no liability here.

5 And here are some of the key facts that go into that  
6 that are completely undisputed, Your Honor. Cardinal Health  
7 distributes only to pharmacies that are licensed by the  
8 state and federal government. And those pharmacies fill  
9 prescriptions written by doctors who are also licensed by  
10 the state and federal government.

11 The medications we distribute, as Your Honor knows, are  
12 approved by the FDA and they're subject to quotas set by the  
13 DEA.

14 Our West Virginia distribution center in Wheeling, the  
15 only distribution center that has served Cabell and  
16 Huntington, has been approved by the Board of Pharmacy and  
17 has never been the subject of a DEA action.

18 There is no evidence of any of our many customers in  
19 Cabell and Huntington diverting. And there's no evidence in  
20 all these days of trial of any specific order that we  
21 shipped that we should not have shipped.

22 So how do plaintiffs get to unreasonable? Well, as  
23 Your Honor knows, the plaintiffs started their case by  
24 saying that there was something unreasonable about all of  
25 our Suspicious Order Monitoring Systems. And we had days

1 and days and days of company witnesses.

2 But when that didn't pan out with the company  
3 witnesses, their entire case became about volume, Your  
4 Honor. They doubled down on volume and volume alone. They  
5 argued yesterday, and they argued throughout this trial,  
6 that the volume of prescription opioid orders we shipped was  
7 inherently unreasonable.

8 THE COURT: Is there some point at which the  
9 number would be so great it would be unreasonable in and of  
10 itself?

11 MS. MAINIGI: I don't think volume alone can be  
12 measured, Your Honor, because the volume has to be tethered  
13 to something. They have to provide the context for the  
14 particular volume.

15 I think -- Mr. Nicholas went over -- let me give you an  
16 example. Mr. Nicholas went over this yesterday and I intend  
17 to just cover it briefly today.

18 Dr. McCann and Ms. Keller both did different  
19 calculations. Dr. McCann did a calculation of distribution.  
20 And -- excuse me. Dr. McCann did a calculation of  
21 distributions and Ms. Keller did a calculation related to  
22 prescriptions.

23 And on cross-examination, Your Honor, she calculated  
24 that the amount distributed into Cabell/Huntington in some  
25 of these relevant years to the pill, to the pill matched up

1 with the prescriptions and the pills that were going out per  
2 the prescriptions.

3 So I think in this case, Your Honor, when there is a  
4 complete one-to-one match-up with the prescriptions that  
5 were written on the one hand and the distributions that went  
6 out from these three distributors on the other, that is  
7 inherently reasonable.

8 And Mr. Rafalski, as I'll go over, Your Honor, backed  
9 that up. He said he wasn't aware of any order that was not  
10 tied ultimately to a prescription.

11 And, in fact, Your Honor, this is a good time for me to  
12 put up the testimony, one piece of testimony from Dr.  
13 McCann.

14 Dr. McCann testified that prescriptions and  
15 distributions are two sides of the same coin. That was Dr.  
16 McCann's testimony. They're two sides of the same coin.  
17 And, so, when those two sides --

18 THE COURT: I'm sorry to interrupt you, but the  
19 overflow room video is not working and we need to reboot it.  
20 I'm sorry to interrupt you.

21 MS. MAINIGI: No rush, Your Honor. Should I wait  
22 right here?

23 (Pause)

24 THE COURT: Okay. I guess we're ready to go.

25 MS. MAINIGI: Okay. Thank you, Your Honor.

1           So two sides of the same coin for distributions and  
2     prescribing.

3           So if we want to understand the number of opioids that  
4     were distributed in Cabell and Huntington, the real question  
5     is why did the doctors write the number of prescriptions  
6     that they wrote.

7           And the Court has heard testimony from the beginning of  
8     this trial about that issue from both sides' witnesses. And  
9     I think you heard from Dr. Deer and Dr. Gilligan, for  
10    example, that from the 1990s through the early 2010s, the  
11    standard of care increasingly called for the use of opioids  
12    to treat pain. And doctors responded by doing that --  
13    exactly that.

14          And Dr. Deer testified that increased prescribing was  
15    entirely reasonable based on the information available at  
16    the time.

17          So we've got two of the country's leading experts,  
18    Dr. Tim Deer, who is from right here in Charleston, and  
19    Dr. Chris Gilligan, who is from Harvard Medical School.

20          Dr. Deer was asked by West Virginia University to  
21    actually draft the state's opioid prescribing guidelines.  
22    And they both testified that the standard of care changed  
23    starting in the mid 1990s to encourage greater use of  
24    opioids. And that trend continued until the last decade.  
25    And that trend happened in West Virginia and it happened

1 nationally.

2 I'm going to put up, Your Honor, a chart that I used  
3 with Dr. Deer. This underlying chart, the blue and orange,  
4 Your Honor, you may remember is the chart that Mr. Farrell  
5 wheeled out in his opening and that he ultimately went over  
6 with Dr. McCann.

7 And the blue and the orange bars are distributions of  
8 oxycodone and hydrocodone in West Virginia.

9 And you can see that the distributions rose as the  
10 standard of care evolved to encourage greater prescribing.  
11 And then the distributions fell as the standard of care  
12 evolved to prescribe fewer opioids.

13 And that makes sense because the distributors' role is  
14 to ensure that medications are available for pharmacies to  
15 fill legitimate prescriptions. And that's exactly what  
16 happened. The distributions tracked the changing standard  
17 of care.

18 Now, let me walk through the timeline, Your Honor, the  
19 evolution of the standard of care.

20 Dr. Deer and Dr. Gilligan both explained that  
21 prescribing opioids for chronic pain wasn't common in the  
22 '80s and the early '90s. Opioids were mainly used after  
23 surgery or at the end of life.

24 In 1996 Purdue launched Oxycontin. And around that  
25 same time period, we saw the adoption of pain as the fifth



1 vital sign. And that meant when a patient was treated at a  
2 hospital or the V.A., they had to be asked their pain level.  
3 And then doctors had to treat them to lower or eliminate  
4 that pain.

5 And there were a lot of influential organizations that  
6 embraced this idea at the time. One of them was the  
7 American Pain Society which was led by a prominent Johns  
8 Hopkins physician.

9 Others in the community began to adopt this concept  
10 pretty broadly. And as I go through -- I'm not going to  
11 pull out -- in the interest of time, Your Honor, I'm not  
12 going to pull out documents to show you. But I handed up to  
13 the Court a binder of documents when we put Dr. Deer on.  
14 And those -- that binder contains all of the documents that  
15 are ultimately on this timeline.

16 So in 2000 the V.A. issued a pain as the fifth vital  
17 sign tool kit. And that instructed providers to evaluate  
18 pain and initiate interventions to relieve it if it was  
19 present at any level, any level.

20 And around that same time, hospitals started adopting  
21 policies to treat the under-treatment of pain.

22 Now, we've heard a lot about the Joint Commission and  
23 that's the body that accredits hospitals around the country.

24 Drs. Deer and Gilligan testified that in 2001 the Joint  
25 Commission made pain as the fifth vital sign. It made it

1 part of its accreditation standards. And then we know, fast  
2 forward, they ultimately got sued by the City of Huntington  
3 for that reason.

4 Now, this change as part of the accreditation standards  
5 required doctors to assess and address pain in every single  
6 patient they saw in a hospital. And, so, doctors responded,  
7 as you would think they would respond, by prescribing more  
8 opioids.

9 Mayor Williams got on the stand here at this trial and  
10 testified that, yes, the City of Huntington sued the Joint  
11 Commission because they thought pain as the fifth vital sign  
12 caused the opioid epidemic.

13 Now, the DEA also helped change the standard of care.  
14 In 2001 the DEA issued a joint statement with 21 health  
15 organizations, including the AMA and The American Cancer  
16 Society. And that statement promoted pain relief.

17 The DEA said the under-treatment of pain was a serious  
18 problem in the United States. And it went on to say that  
19 opioid medications are often the most effective way to treat  
20 pain. And they're the -- and most often, they're the only  
21 treatment option that provides significant relief to  
22 patients.

23 Now, while some of this stuff was happening nationally,  
24 the same type of thing was happening in West Virginia, as we  
25 know.

1           In 1997 -- and West Virginia was even a little bit  
2 ahead of the curve. In 1997 the State Board of Medicine put  
3 out a statement telling doctors pain was under-treated. And  
4 it told doctors not to fear discipline for treating chronic  
5 pain, chronic pain, not end of life pain, not cancer pain,  
6 but chronic pain with opioid medication even in large doses.  
7 And that "even in large doses" is a direct quote, Your  
8 Honor.

9           So the next year in 1998 the State Legislature of West  
10 Virginia made that statement official. And they passed  
11 something called the Intractable Pain Act. And that act did  
12 two major things.

13           First, it encouraged doctors to prescribe opioids more  
14 freely. And, second, it made clear that if they did,  
15 disciplinary action would be limited.

16           Your Honor, if you don't mind, I'll just give you a  
17 copy of the slides right now. It might be easier to read  
18 that.

19           THE COURT: That would be great. Thank you very  
20 much.

21           MS. MAINIGI: I think it's just a few pages in. I  
22 know it's a little tight on the chart.

23           So the Intractable Pain Act in 1998 encouraging doctors  
24 to prescribe more opioids, and then making clear that if  
25 they did, disciplinary actions would be limited. And those

1 two actions in '97 and '98 helped to start shifting the  
2 standard of care in West Virginia.

3 In 2001 the Board of Medicine in West Virginia issued a  
4 joint policy statement on pain management at the end of  
5 life. And in that policy statement, they continued to  
6 encourage the use of opioids for pain. And they actually  
7 said to doctors, "Don't shy away from prescribing opioids  
8 just because they might be misused."

9 In 2005 the Board of Medicine again encouraged opioid  
10 prescribing through another statement that went to doctors.  
11 And that statement said under-treating pain --  
12 under-treating pain constituted inappropriate treatment  
13 which could expose a doctor to discipline.

14 So let's think about how quickly things changed.

15 In 1998 the Legislature felt they had to protect  
16 doctors from getting in trouble for prescribing too many  
17 opioids. But by 2005 in West Virginia, the Board of  
18 Medicine was telling doctors they could get in trouble for  
19 not prescribing enough opioids.

20 Now, that same year in 2005 the state AG at the time  
21 joined in. And he and other Attorneys General wrote the DEA  
22 to express their concern that there was too much focus on  
23 anti-diversion and not enough focus on the treatment of  
24 pain.

25 And Dr. Deer told us when he came to testify that that

1 AG letter was reprinted in the Board of Medicine newsletter  
2 that went to every licensed doctor in the state.

3 Now, West Virginia going into 2009 and 2010, West  
4 Virginia continued to promote opioids to treat pain.

5 So in 2009, the Legislature actually amended the  
6 Intractable Pain Act, the one that was passed in 1998. And  
7 they amended it to remove the word "intractable."

8 Dr. Deer testified that this made it easier for doctors  
9 to prescribe opioids for patients with less severe pain, not  
10 just intractable pain. And they were able to prescribe for  
11 less severe pain without a fear of consequence.

12 And in 2010 the Board of Medicine re-adopted the same  
13 joint statement on pain management that it had put out in  
14 2001.

15 Now, while all of these laws and policies were  
16 changing, Dr. Deer explained to us that in the background of  
17 all of this, continuing education for doctors also increased  
18 opioid prescribing.

19 And I think that you've seen a few times, and I think  
20 that you have a copy of, Your Honor, this book called  
21 *Responsible Opioid Prescribing* by Dr. Fishman. And this  
22 book is important because it's, it's a key example of a book  
23 that was handed out to doctors in West Virginia by the Board  
24 of Medicine. And the book essentially urges doctors to  
25 prescribe opioids more liberally. It was sent to every

1 doctor in West Virginia.

2 And the plaintiffs' own complaint said that  
3 Dr. Fishman's book was a major reason that prescribing went  
4 up in West Virginia.

5 And West Virginia wasn't alone. There were a number of  
6 states that actually sent that book out to doctors. And I  
7 think Your Honor even heard during trial an example of a  
8 doctor who had to write a book report about Dr. Fishman's  
9 book as part of a disciplinary action.

10 And Dr. Deer told us when he was here that the Board of  
11 Medicine required doctors to watch a lecture by Dr. Fishman  
12 in order to renew their licenses.

13 So Dr. Deer concluded that all of these laws, education  
14 programs and policies, those resulted in the increased  
15 opioid prescribing across the state.

16 Now, what he also testified to was that doctors who  
17 were doing that prescribing were acting reasonably and  
18 following the standard of care. And he was asked that  
19 question and he said, "I think at the time, the vast  
20 majority of those doctors were acting within reasonable  
21 medical standards and standard of care."

22 And you saw from the chart, Your Honor, that as  
23 prescribing went up, distributions, of course, went up too.

24 So we come back to the timeline. The standard of care  
25 pendulum begins to shift around 2012 in West Virginia. And

1 it starts to shift in the other direction.

2 And in that year, in 2012, the West Virginia  
3 Legislature passed the Controlled Substances Monitoring  
4 Program and Chronic Pain Clinic Licensing Act. It's a  
5 mouthful of an act. And this act did two things also.

6 It required doctors to check a prescribing database to  
7 spot doctor-shopping. Now, why was that important? Because  
8 there were people that were going to multiple doctors  
9 perhaps to get the same prescription.

10 So doctors now actually had to take -- had to check a  
11 database that was available to them, not available to  
12 distributors, but available to them as physicians to see if  
13 anyone else, any other doctor had prescribed a controlled  
14 substance to that same patient. The act also required pain  
15 clinics to have special licenses.

16 Now, in the last several years in particular, the  
17 medical community, as well -- in West Virginia, as well as  
18 the rest of the country, has moved towards more conservative  
19 prescribing of opioids.

20 In 2016 the seminal event was that the CDC issued new  
21 guidelines that recommended quantity and dosage limits for  
22 prescribing opioids, actual limits on how much opioids one  
23 could prescribe.

24 So West Virginia followed. And later that year, a  
25 panel of doctors that was led by Dr. Deer issued the SEMP

1 guidelines. And the purpose of the SEMP guidelines was to  
2 essentially translate the CDC guidelines into practical  
3 advice for physicians in West Virginia.

4 Then in 2018 the -- the West Virginia Legislature took  
5 even stronger action and they passed the West Virginia  
6 Opioid Reduction Act which for the first time limited the  
7 number of pills doctors could prescribe.

8 And, so, you see ultimately prescriptions falling. And  
9 as prescriptions fell, distributions fell.

10 What was striking about the issue of standard of care,  
11 Your Honor, throughout this trial was how much of the  
12 standard of care evidence actually came from the plaintiffs'  
13 own witnesses long before we got to Dr. Gilligan and Dr.  
14 Deer in our case.

15 So Dr. Werthammer was a plaintiffs' witness. He's the  
16 former Chief Medical Officer at Marshall Health. And  
17 Dr. Werthammer agreed that pain as the fifth vital sign led  
18 to more liberal opioid prescribing.

19 Dr. Gupta, who was the Health Commissioner and  
20 Secretary of the Board of Medicine, he testified that most  
21 doctors in the state were prescribing in line with the  
22 standard of care and trying to do the right thing. And he  
23 said that prescribing opioids to treat pain was their  
24 education. It was their understanding. And it was their  
25 culture.



1 Dr. Corey Waller, who was the plaintiffs' very first  
2 witness who talked about molecules, he confirmed the  
3 standard of care change. And he also said pain had to be  
4 treated, and the general gestalt in the medical community  
5 was that prescription opioids were the only way to do it.

6 Even Dr. Katherine Keyes, plaintiffs' epidemiologist,  
7 she agreed that opioid prescribing rose from the late '90s  
8 until 2010. And she said -- I'll read this out loud.

9 "As I've said before, the doctor is making a  
10 determination based on their understanding of the risks and  
11 benefits of a particular opioid prescribing, which itself  
12 has changed over time. You know, certainly, the  
13 recommendations for prescribing have changed quite a lot  
14 over the last 10 years."

15 Now, Dr. Kevin Yingling who's local to Marshall, he  
16 testified that he also came to believe that pain was  
17 under-treated in the late 1990s. And he said doctors were  
18 urged to treat pain more aggressively. He said he and other  
19 local doctors prescribe more opioids in part because of pain  
20 as the fifth vital sign.

21 And one of the other things he said, as you see at the  
22 bottom, Your Honor, is distributors have never had an effect  
23 on his prescribing behavior.

24 Now, he also told us, Your Honor, that there's a debate  
25 in the medical community that's going on still today as to

1 whether opioid prescribing restrictions have now gone too  
2 far, whether they are too strict, and whether they are  
3 actually now hurting patients in real pain.

4 Now, Your Honor, to be clear, we do not think that Your  
5 Honor is tasked with deciding whether the standard of care  
6 for prescribing opioid medications in retrospect was right  
7 or wrong. You don't have to decide that in our view.

8 But what the Court has to evaluate here is whether  
9 defendants' conduct, including their shipments over time,  
10 was reasonable in light of the standard of care and its  
11 impact on prescribing.

12 So whether it was right or wrong, there's no dispute  
13 about the change in the standard of care. And there's no  
14 dispute that distributors played no role in that change.  
15 Not a single witness testified to that fact.

16 And what we know from Dr. Gilligan and others is that  
17 opioids, like all medications, have always carried risks.  
18 He testified that it was inevitable that with the  
19 prescribing of opioids comes some level of abuse and  
20 addiction, but that doctors must make the decision on how to  
21 strike that balance.

22 Now, I think some of this testimony got shown to you  
23 yesterday, Your Honor. And, and the plaintiffs put it out  
24 there as something that somehow supports the idea of  
25 foreseeability. But I, I think that they are missing the

1 point.

2 I think what this testimony supports is that doctors  
3 have to make the decision on a patient-by-patient basis  
4 whether the risks of opioids outweigh the benefits. And the  
5 distributors do not have the information or the medical  
6 expertise to make that decision, and they should not ever be  
7 put in the position of trying.

8 Distributors cannot unilaterally decide to stop  
9 shipping an FDA approved medication simply because a certain  
10 portion of the population may experience what is known as a  
11 known risk.

12 Now, Mr. Rannazzisi even testified and agreed that  
13 distributors have never been required to monitor prescribers  
14 or prescribing practices. He said we never required them to  
15 look at what doctors were doing, questioning a doctor's  
16 prescribing habits.

17 Speaking of the DEA, there's another important place  
18 where the change in the standard of care was reflected, Your  
19 Honor, and that's the DEA opioid quota.

20 So we put Dr. Deer's timeline back up. This shows, as  
21 I mentioned, the West Virginia distribution. I think we  
22 also showed you at some point during trial the DEA quota  
23 chart.

24 And if we can put that up, the point that I want to  
25 make, Your Honor, is that the quota trend line matches the

1 distribution trend line which, again, makes perfect sense  
2 because the DEA sets the quota every year based on  
3 legitimate medical needs. That is how they are obligated to  
4 set the quota, based on legitimate medical need. And every  
5 year, they've raised the quota because the standard of care  
6 was changing.

7 Now, to his credit, Mr. Rannazzisi fully acknowledged  
8 that he approved major quota increases. And when Ms. Singer  
9 asked him why he approved such large increases over his 10  
10 years as the head of DEA enforcement, he said it was to  
11 ensure that there was enough quota for patients.

12 So as more prescriptions were going out of pharmacies  
13 and hospitals, the quota was increased by the DEA to meet  
14 the patients' medical needs.

15 Now, stepping back, Your Honor, given where Cardinal  
16 Health sits and their vantage point, the increasing orders  
17 that Cardinal Health was receiving made perfect sense.

18 If Cardinal Health looked downstream, it saw what  
19 everyone else was seeing; that doctors across the country  
20 were prescribing more opioids.

21 And if it looked upstream, it saw that the DEA was  
22 publicly saying that 99 percent of doctors are prescribing  
23 opioids appropriately and the DEA was finding that  
24 legitimate medical need was increasing year after year and  
25 raising the quota.

1           So there is absolutely no reason, Your Honor, why the  
2           increasing orders pursuant to the changing standard of care  
3           and the DEA quota, there's no reason why those orders should  
4           have been alarming to Cardinal Health.

5           Now, the plaintiffs have focused on the  
6           Cabell/Huntington volume. And they've said, well, maybe the  
7           standard of care explained what was happening nationally,  
8           but you can't explain the volume coming into Cabell and  
9           Huntington. And I think they're wrong about that.

10          Now, before we unpack the reasons why and the evidence  
11          that we saw at trial, I just want to remind Your Honor of  
12          one thing.

13          And that is as Dr. McCann testified, going back as  
14          early as 1998, DEA has published on its website the volume  
15          of prescription opioids shipped down to the three-digit zip  
16          codes.

17          So back to 1998, that data was available to anyone who  
18          wanted it, including city and county officials.

19          But before this lawsuit was filed, no one, not the DEA,  
20          not the State of West Virginia, not the plaintiffs, ever  
21          said that the raw volume of opioids being shipped to Cabell  
22          or Huntington was too high or that distributors should have  
23          shipped fewer pills.

24          So let me turn to five pieces of evidence from trial  
25          that inform specifically the volume shipped to Cabell County

1 and Huntington.

2 Now, the first one is the one that, that I went over  
3 with Your Honor. And I think taking a look at the chart,  
4 one of the charts that Mr. Nicholas showed you yesterday,  
5 this chart described the prescribing in Cabell/Huntington  
6 from Ms. Keller lining up with the distributions from Dr.  
7 McCann.

8 But if we keep going to the next slide, we see the  
9 calculation that was actually done by Ms. Keller. And I  
10 think on cross Ms. Wicht asked her to do the math. And  
11 Dr. Keller got the math right when she did it on cross.

12 And what she calculated, that the prescriptions that  
13 she had information on came to -- for 2006-2014 in Cabell  
14 County, 141.2 pills per person, and that the distributions  
15 that Dr. McCann had calculated came to 142.19 pills per  
16 person.

17 I think, as Mr. Nicholas said yesterday, that number  
18 right there, or those two numbers right there are absolutely  
19 amazing in terms of how they match up basically to the pill.  
20 And to her credit, Ms. Keller made that concession, that  
21 they match up to the pill.

22 Now, what's also remarkable is this conclusion is  
23 consistent with something Mr. Rafalski also said.

24 Mr. Rafalski's testimony was that he was not aware of  
25 any pills, any pills shipped by McKesson, ABDC, or Cardinal

1 that ended up doing anything other than filling  
2 prescriptions written by licensed prescribers.

3 The second piece of evidence that relates to Cabell and  
4 Huntington. The evidence was overwhelming at trial, Your  
5 Honor, and I won't belabor it, that the prescribing that was  
6 done nationally, but also in Cabell and Huntington, was done  
7 in good faith, and virtually all the prescriptions were  
8 legitimate.

9 So we've already seen Mr. Rannazzisi with the reference  
10 to 99.5 percent of prescribers not over-prescribing. And  
11 we're familiar with this quote, but I want to remind the  
12 Court that Dr. Rafalski -- or Mr. Rafalski also said the  
13 same thing. Mr. Rafalski also agreed that 99 percent of  
14 doctors prescribe opioids for legitimate medical purposes.

15 Now, one piece of evidence we haven't seen that often  
16 so far, Your Honor, is that in 2006 the DEA went so far as  
17 to say in the Federal Register that, quote, nearly every  
18 prescription issued by a physician in the United States is  
19 for a legitimate medical purpose in the usual course of  
20 professional practice. And not a single witness disputed  
21 that.

22 And as Your Honor knows, to the contrary, witness after  
23 witness on the plaintiffs' side agreed that the vast  
24 majority of doctors prescribed opioids in good faith based  
25 on the information that they had at the time.

1           So, again, Dr. Waller said doctors who were prescribing  
2           opioid medications for chronic non-cancer pain were acting  
3           in good faith. Even Dr. Keyes said the overwhelming  
4           majority of doctors prescribed opioids to their patients in  
5           good faith. And then our local witnesses also agreed that  
6           this was true in Cabell and Huntington.

7           So Dr. Yingling testified that the use of prescription  
8           opioids in Cabell County is within the bounds of medically  
9           accepted practice.

10          In Huntington Mayor Steve Williams said that he even  
11          believed that the vast majority of doctors in Cabell County  
12          and Huntington thought they were prescribing opioids  
13          appropriately. Another key piece of evidence, Your Honor,  
14          that informed the volume in Cabell and Huntington.

15          Another way that you know that the volume shipped to  
16          Cabell and Huntington was reasonable is because the  
17          magnitude of the increase in distributions into Cabell and  
18          Huntington over time was the same as the magnitude of the  
19          increase in West Virginia, as well as the nation.

20          So to the extent that Cabell and Huntington ended at a  
21          higher rate or at a higher number, Your Honor, that's  
22          because they started higher.

23          So let me explain this slide. So the far left slide,  
24          Your Honor, shows distributions nationwide. These are Dr.  
25          McCann's charts, not our charts. And the middle bottom



1 shows distributions in West Virginia. And the far right  
2 shows distributions in Cabell and Huntington. And up top we  
3 have the same nationwide -- the DEA quota chart we were just  
4 looking at.

5 And what Dr. McCann showed us is that distributions in  
6 Cabell and Huntington rose by the same factor as  
7 distributions into West Virginia and nationally, and even by  
8 the same factor as the DEA quota.

9 So let me show you his testimony. Dr. McCann told us  
10 that from 1997 to 2010 there is a ten-fold increase across  
11 each of these charts, overall quota, West Virginia and  
12 Cabell/Huntington. Everybody increased at the same ten-fold  
13 rate.

14 Well, if the trend is the same, why did Cabell and  
15 Huntington end up higher on a per capita basis compared to  
16 the nation or even West Virginia?

17 And the evidence shows it's because they started  
18 higher. Even in 1997, Your Honor, before any of the conduct  
19 that plaintiffs allege was wrongful in this case, per capita  
20 opioid distribution and, therefore, prescribing was already  
21 higher in Cabell and Huntington than it was nationally or  
22 statewide.

23 And that's because of the fourth piece of evidence,  
24 Your Honor. West Virginia and, in particular, Cabell and  
25 Huntington, have higher rates of pain-causing conditions

1 and, therefore, higher rates of prescribing. And that's  
2 always been the case, or been the case for a significant  
3 amount of time.

4 Now, Drs. Gupta and Deer, who know these populations  
5 well, each testified about this.

6 So Dr. Gupta told us that West Virginia ranks number  
7 one in the country in total prescriptions per capita. So  
8 not opioid prescriptions, but number one in the country in  
9 total prescriptions per capita. So West Virginia doctors  
10 prescribe more medications overall.

11 As of 2016 -- this is from one of Dr. Gupta's  
12 reports -- the average West Virginian received 20.8  
13 prescriptions per year which was far higher than the  
14 national average of 12.6 prescriptions per year.

15 And Dr. Gupta also testified that West Virginia has  
16 higher rates of pain-causing conditions compared to other  
17 parts of the country which leads to more opioid prescribing.

18 And he had a presentation that we went over with him  
19 that showed West Virginia's higher rates of pain-causing  
20 health conditions.

21 So West Virginia has ranked in the West Virginia charts  
22 number one in the nation in arthritis, number one in  
23 cardiovascular disease, number one in obesity, number one in  
24 COPD, and number one in high blood pressure.

25 It's ranked number two in diabetes and number two in

1 depression, and number three in cancer.

2 Now, the additional part of the explanation for some of  
3 these numbers was provided to us by Dr. Deer. West Virginia  
4 has an older population, he told us, which tends to suffer,  
5 of course, from more pain-causing conditions.

6 And he also told us that West Virginians work in  
7 physically demanding jobs, more so than their counterparts  
8 in other states. So there are more work-related injuries.

9 And even Dr. Keyes agreed with that. Dr. Keyes was  
10 cross-examined on an article that she published before she  
11 became an expert in this litigation on why people in rural  
12 areas abuse opioids more.

13 And she said, like Dr. Deer, that rural populations are  
14 older and have higher rates of chronic pain and injury. And  
15 that's why she would expect to see higher levels of opioid  
16 prescribing in West Virginia than in other states.

17 We also heard from Dr. Deer and then Dr. James Hughes  
18 on insurance providers, including Medicaid and Workers'  
19 Comp. And we've heard how those providers restricted  
20 non-opioid pain treatment which led to patients staying on  
21 opioids longer.

22 Dr. Hughes explained that West Virginia had unusually  
23 limited coverage of, for example, chiropractors and physical  
24 therapy, and that other states by contrast covered much more  
25 and made it easier to get non-opioid alternatives.

1           And all of these reasons ultimately magnified why the  
2           numbers in Cabell and Huntington were higher. And if we  
3           focus in just on Cabell and Huntington, I think we heard  
4           testimony from Mayor Williams that in 2008 the CDC reported  
5           that Huntington, unfortunately, had the worst health rating  
6           of any city in America and had higher -- had the highest  
7           rates of certain conditions relative to any other city in  
8           America. And Dr. -- Mayor Williams told us when he was here  
9           testifying that all of that was true.

10           Another piece of evidence we heard from Dr. Yingling is  
11           that people from neighboring counties actually come to  
12           Huntington for medical care which helps to raise the  
13           prescribing rates in the Huntington/Cabell area.

14           And Dr. Yingling called Huntington a hub of healthcare  
15           and noted that it had several hospitals and healthcare  
16           centers which, of course, one of them is the V.A.

17           Let me make one final point on the volume as it relates  
18           to Cabell and Huntington, Your Honor.

19           The overall ratio of Cardinal Health controlled  
20           substances shipments coming into Cabell and Huntington fit  
21           perfectly with the DEA's expectations. The ratio of  
22           controlled substances to all medications shipped is a key  
23           factor recognized by the DEA for distributors evaluating  
24           pharmacies.

25           Mr. McDonald, our data expert, looked to statements

1 from the DEA that a distributor could expect controlled  
2 substances to be anywhere from 5 to 20 percent, 5 to  
3 20 percent of its shipments to pharmacies.

4 Mr. McDonald did the calculation. And he calculated  
5 that Cardinal's number for Cabell and Huntington was  
6 14.9 percent, so well within the DEA expected range of 5 to  
7 20 percent. And opioids -- if we look just at opioids, they  
8 were just 7 percent.

9 So Cardinal Health's opioids shipments to Cabell and  
10 Huntington were completely reasonable given the total number  
11 of prescriptions that doctors wrote for all medications.

12 To sum up on volume, Your Honor, the standard of care  
13 for pain management changed drastically. Doctors in West  
14 Virginia and around the country prescribed opioids far more  
15 often than they had in the early '90s. And nearly all of  
16 them did so in good faith. And they could have been  
17 disciplined if they hadn't.

18 West Virginia and Cabell County had higher than average  
19 opioid prescribing rates, but they also had higher rates of  
20 prescribing for all medications. And that's because they  
21 had some of the worst overall health statistics in the  
22 country.

23 So controlled substances were not an unusually high  
24 percentage of our distributions in Cabell County. And over  
25 the entire time span in question, Cabell County's rates of

1       opioid prescribing grew at exactly the national average.

2               The number of pills we distributed there was exactly  
3       the number that doctors prescribed. And not one word, Your  
4       Honor, in the summary that I just gave you is disputed.

5               Plaintiffs have given the Court no basis whatsoever to  
6       find that Cardinal's distribution volume in Cabell and  
7       Huntington was unreasonable.

8               Now, that's volume, Your Honor.

9               Did the plaintiffs show that our systems, our  
10       Suspicious Order Monitoring Systems allowed orders to be  
11       filled there?

12               THE COURT: Do you want to take a break,  
13       Ms. Mainigi?

14               MS. MAINIGI: Yes. I think that would be  
15       wonderful, Your Honor.

16               THE COURT: Okay. This looked like a time to do  
17       it.

18               MS. MAINIGI: This is a perfect time. Thank you,  
19       Your Honor.

20               THE COURT: All right. We'll be in recess for  
21       about 10.

22               (Recess taken from 10:00 a.m. until 10:14 a.m.)

23               MS. MAINIGI: Thank you for the break, Your Honor.

24               During the break, I was reminded by some of my smarter  
25       colleagues of Dr. Murphy's testimony. I think you had asked

1 or suggested that some economists might say supply affects  
2 demand. But I think you probably remember that Dr. Murphy  
3 addressed that specific question --

4 THE COURT: He did.

5 MS. MAINIGI: -- for this industry. And you  
6 remember it better than I do, Your Honor.

7 THE COURT: I didn't ask him the question because  
8 I didn't know how to pronounce Say Fa (phonetic). I don't  
9 know French so --

10 MS. MAINIGI: Well, I can't pronounce it either,  
11 Your Honor, unfortunately. But I do, I do know now and have  
12 been reminded that Dr. Murphy testified that in this  
13 industry, the industry that we're in, our distribution does  
14 not drive demand.

15 And, and the chief reason for that, obviously, is  
16 because a patient cannot get a prescription without --  
17 cannot get the medication without a prescription. And that  
18 was, I think, Dr. Murphy's testimony pretty clearly.

19 So, Your Honor, where I had -- I'm sorry, Your Honor.  
20 Did you have another question?

21 THE COURT: No. You can go ahead.

22 MS. MAINIGI: Thank you.

23 So let me shift over. I know I said earlier that the,  
24 the plaintiffs did not spend a lot of time on our systems,  
25 our Suspicious Order Monitoring Systems. But I do want to

1 outline for the Court some basics related to those systems.

2 So you can think of Cardinal Health system in basically  
3 three eras. And I think you heard a little bit about this  
4 when Mr. Mone testified.

5 So you've got pre-2008. You've got 2008 to 2012. And  
6 then you've got 2012 through the present.

7 And until 2008, the Cardinal system was led by a former  
8 law enforcement officer named Steve Reardon. And he had  
9 been with the company since the 1980s.

10 And under Mr. Reardon's leadership, Cardinal Health  
11 operated a Suspicious Order Monitoring System that was very  
12 similar to the other programs around the country. It had a  
13 couple of components. It had suspicious order reporting and  
14 due diligence on the pharmacy customers.

15 And Cardinal sent monthly reports to the DEA called  
16 Ingredient Limit Reports. And those Ingredient Limit  
17 Reports were based on a computer program that compared  
18 customer purchases to pre-determined limits.

19 And if a customer's purchase exceeded the limit, then  
20 their order went into the report. And then the report  
21 itself went to the DEA after the orders were shipped.

22 Now, there was another component that involved folks  
23 called pickers and checkers. And it was their job to also  
24 identify excessive orders based on their own particular  
25 experience in the distribution centers with customers.



1 And orders that they identified could be stopped right  
2 there at the distribution center and reported to the DEA  
3 before they were shipped. So the distribution center could  
4 stop orders it thought might be excessive or suspicious.

5 The key takeaway, Your Honor, I think for the pre-2008  
6 system is that the DEA understood Cardinal's program and it  
7 was completely consistent with what other distributors were  
8 doing and the DEA expectations at the time.

9 So the Court has the depo designation, deposition  
10 designation for Mr. Michael Mapes who was the DEA diversion  
11 investigator. And he testified about the submission of  
12 these Ingredient Limit Reports. Some companies called them  
13 Excessive Purchase Reports.

14 And I think those were the reports that were part of  
15 the ABDC system that Mr. Nicholas talked about yesterday.  
16 And as Mr. Nicholas told you, the DEA expressly approved  
17 ABDC's program which, like Cardinal Health's program,  
18 reported suspicious orders after they had been shipped until  
19 that 2008 forward time period.

20 Let me go ahead and just play the clip where Mr. Mapes  
21 testified to that.

22 (A video clip was played as follows:)

23 "Was the submission of Excessive Purchase Reports in  
24 your experience standard practice in the industry?

25 It was.

1           And in your experience, DEA viewed those reports as  
2           compliant with the Controlled Substances Act?

3           Yeah. I viewed those as compliant with the regulation  
4           for suspicious orders."

5           (Video clip concluded)

6           MS. MAINIGI: And I think that there is other such  
7           testimony in the record as well.

8           But Mr. Mapes who had responsibility, along with Kyle  
9           Wright, over several of the distributors, several of the  
10          major distributors, certainly testified that he viewed the  
11          process that was followed in the pre-2008 time period to be  
12          consistent with the DEA expectations.

13          Now, I think, as Your Honor has heard in the first few  
14          weeks of trial, toward the end of 2007 the DEA changed its  
15          expectations about shipping suspicious orders and about  
16          Suspicious Order Monitoring Systems as well.

17          And as Mr. Nicholas told you, AmerisourceBergen  
18          developed a next generation monitoring program in response  
19          to this new DEA guidance. And ABDC and the DEA jointly  
20          presented that program at an industry conference in  
21          September of 2007.

22          The DEA used that presentation, as we heard, to tell  
23          the industry what it wanted to see in monitoring programs  
24          going forward.

25          And the biggest change, as you heard in the early weeks

1 of trial, was that the DEA from that point forward no longer  
2 wanted distributors to ship suspicious orders.

3 And, so, when the DEA announced in September, 2007 that  
4 it wanted ABDC's new system to be the model, Cardinal Health  
5 complied.

6 Now, what I want to show Your Honor is an email,  
7 September, 2000 email -- 2007 email from Mr. Reardon. So  
8 we're about to go through a transition period. But  
9 Mr. Reardon sent this email after the conference he had just  
10 attended.

11 And, in fact, it says final summary of DEA meeting  
12 dated 9/7/07. The email itself is seven days later on  
13 September 14th.

14 And among other things, Mr. Reardon tells his  
15 colleagues back at Cardinal, "DEA is setting a new standard  
16 with which we must comply."

17 And then he explains why.

18 And then he says also, "DEA referred to the ABC program  
19 as the new industry standard. I will be setting up a  
20 meeting to initiate discussions on this topic in the near  
21 future."

22 So Cardinal, after that point, set about revamping its  
23 Suspicious Order Monitoring System to essentially echo what  
24 it had seen in the presentation at the September, 2007  
25 conference.

1           And in furtherance of that, in December, 2007, Cardinal  
2           hired Michael Mone who Your Honor heard from live here at  
3           trial. Mr. Mone came in to supervise the anti-diversion  
4           program and the on-going enhancement of that program.

5           And he was an important addition to the Cardinal team  
6           because as Your Honor may recall, he was both a pharmacist  
7           and a lawyer, and he had run a state Board of Pharmacy and  
8           practiced in the state AG's office.

9           He had also -- while he had the other roles, he had  
10          helped to create one of the first state prescription drug  
11          monitoring programs in the country.

12          So when he came in and took over, Cardinal Health was  
13          already in the process of implementing what it had learned  
14          at the September, 2007 conference. And he told us on the  
15          stand about essentially the three components of the Cardinal  
16          Health system.

17          The Know Your Customer component involved a detailed  
18          evaluation and due diligence effort on new customers, as  
19          well as on-going diligence of existing customers. A new  
20          customer approval was not automatic. Cardinal Health  
21          rejected some customers because of diversion concerns.

22          The second piece was electronic order monitoring. And  
23          as part of that piece, a customized threshold for each drug  
24          family was set for each customer. And the system now  
25          automatically held orders over the threshold.

1           And then the held orders were evaluated by the  
2 anti-diversion team which included several pharmacists.

3           Then when the investigation ceased, there were regular  
4 site visits that were made to the customer by former police  
5 and former investigators from the DEA, Medicaid, and Board  
6 of Pharmacy.

7           And then there was an analytical -- an analytics team  
8 that was also set up to create reports, evaluate thresholds,  
9 re-examine thresholds.

10          So Cardinal moved quickly to get into place a new  
11 system that essentially embraced the components that the DEA  
12 said it wanted embraced.

13          And all of this information, Your Honor, is in the  
14 standard operating procedures that Mr. Mone testified about.  
15 And, again, just like in the prior time period, Cardinal  
16 kept the DEA up-to-date on what it was doing.

17          So in 2009, as Mr. Mone testified, the chief of the  
18 DEA's regulatory section was a woman named Barbara  
19 Boockholdt. And Mr. Mone told us early in 2009 he met with  
20 her and her team in person for a full week. And they  
21 reviewed the company's updated system in detail.

22          Mr. Mone told us that he covered with her how  
23 thresholds were set and identified and how the company was  
24 handling suspicious orders. And to the -- I think I heard  
25 some reference yesterday from the plaintiffs about the

1 multiplier for thresholds.

2 To the extent that a multiplier was used as part of our  
3 threshold setting system, the DEA was aware of it and did  
4 not raise any concerns.

5 And Mr. Mone told us that at the end of the week, the  
6 DEA didn't offer a single complaint or ask for a single  
7 change. And Mr. Mone stayed in touch with Ms. Boockholdt  
8 after that and talked to her regularly about whatever  
9 improvements the DEA was looking for from distributors.

10 Now, the DEA guidance that came out in a variety of  
11 ways evolved again in the 2012 time period. And the DEA  
12 changed its focus in that time period to numbers; data  
13 analytics and quantitative measurements.

14 And, so, Cardinal Health added new metrics to analyze  
15 if pharmacy customers changed its threshold setting  
16 procedure. And because of the new focus, Cardinal brought  
17 in someone that had that specific expertise, Todd Cameron  
18 who has run our anti-diversion program since 2012.

19 Now, Mr. Cameron may not look familiar to you, Your  
20 Honor. The plaintiffs had asked us to make Mr. Cameron  
21 available to testify in their case, and we did make him  
22 available to testify. He was here in Charleston waiting to  
23 take the stand when plaintiffs let us know that they no  
24 longer wanted to put him up ultimately as a witness.

25 The bottom line, Your Honor, is that the plaintiffs

1 have essentially presented no evidence and have no  
2 complaints, as far as we have heard during this trial, about  
3 Cardinal Health's program after 2012. They didn't mention  
4 it in opening, and they haven't mentioned it in closings  
5 either.

6 So I'm not going to spend too much time on the 2012  
7 system, but we'll cover the 2012 system in our findings of  
8 fact ultimately so that Your Honor has a complete record.

9 But, essentially, the components of the system stayed  
10 the same per the DEA guidance. There was still a --

11 Matt, if we could put up that slide.

12 There was still a Know Your Customer component and  
13 electronic order monitoring component and an investigation  
14 component. But the various types of criteria that were used  
15 were certainly altered to comply with the expectations from  
16 the DEA.

17 And Cardinal put together a committee also called a  
18 Large Volume Tactical and Analytical Committee that included  
19 anti-diversion professionals and senior Cardinal officials.  
20 And its entire purpose was to review large orders from  
21 customers as they came through.

22 And then the diligence files. The diligence files in  
23 evidence also show Cardinal Health continuing its practice  
24 of regular site investigations and visits of its customers.

25 And as we'll state in our findings of fact, Your Honor,

1 Mr. Cameron has presented this program to the DEA several  
2 times, the current program at -- as it has evolved. And  
3 there's no evidence that DEA has found any fault with that  
4 program since 2012.

5 Now, what have plaintiffs chose to focus on then when  
6 it comes to the SOMS system? They haven't gone into the  
7 specifics. What they do is point occasionally to Cardinal's  
8 2008 and 2012 Settlement Agreements.

9 But there is no connection, Your Honor, between those  
10 agreements and West Virginia. There is not evidence through  
11 those agreements of any sort of systemic failure or any  
12 unreasonable conduct related to Cabell County or Huntington.

13 Let me review those two agreements with you.

14 The 2008 DEA action had to do, Your Honor, with  
15 shipments to internet pharmacies which are not at issue in  
16 this case.

17 And it had to do with shipments to internet pharmacies  
18 from our distribution centers in Texas, New Jersey,  
19 Washington, and Florida. And none of those distribution  
20 centers shipped to Cabell/Huntington as Dr. McCann admitted  
21 when he was on the stand.

22 The Wheeling distribution center is the only one that  
23 shipped to Cabell and Huntington. And it had never had a  
24 DEA enforcement action.

25 The 2012 DEA action, Your Honor, had to do with just



1 four specific pharmacies, so not four distribution centers  
2 even, but four specific pharmacies in Florida that were  
3 served by our Lakeland, Florida, distribution center.

4 And before the DEA even took action, we had already  
5 terminated two of those four pharmacies. And to give you  
6 some context, Your Honor, those are four pharmacy customers  
7 out of our 29,000 pharmacy customers.

8 Now, what else did they do besides the settlement  
9 agreements? The plaintiffs continue to cite to Mr.  
10 Rafalski. Now, we already know -- in our view, he already  
11 has a major *Daubert* problem and we've obviously briefed that  
12 issue.

13 But even if Your Honor does not exclude his testimony,  
14 his testimony is just not credible and far too generic and  
15 unsupported to be the basis for this Court to find  
16 unreasonableness.

17 So taking a look at what Mr. Rafalski actually did or  
18 did not do, to be more precise, Mr. Rafalski admitted that  
19 he didn't look at all the due diligence for the orders  
20 flagged by his methodology. Only some he said. But we know  
21 he didn't even look at the initial orders flagged under his  
22 methodology to see if he could call them suspicious.

23 He conceded he had no idea how many of the orders he  
24 flagged were investigated and cleared by Cardinal Health.  
25 He doesn't know if we investigated 0 percent or 100 percent

1 of them. And he didn't even try to figure it out.

2 He conceded, Your Honor, that he didn't know which  
3 orders were actually suspicious and should have been  
4 reported to the DEA, or if there were any of those orders at  
5 all. He had no idea whether there was any single suspicious  
6 order that we did not report.

7 And he conceded he did not evaluate how many of his  
8 flagged orders went to meet legitimate medical needs. So he  
9 also doesn't know which orders, if any, were actually  
10 diverted.

11 He didn't do the work he needed to do, Your Honor, is  
12 the basic bottom line. And he didn't do that work for any  
13 of the three distributors.

14 Now, just briefly on his methodology. I think it can  
15 be summed up pretty well with what's on the screen. No  
16 one's ever used them in the real world, his methodologies,  
17 not the DEA or any distributor. He made them up for this  
18 litigation.

19 After making up six of them, he said there were four of  
20 them he would not use. And he conceded that there's a huge  
21 number of other flagging systems that could also comply with  
22 the law.

23 Now, when Mr. McDonald applied Mr. Rafalski's  
24 90 percent methodology, his Methodology A, he testified that  
25 Mr. Rafalski's Method A flagged 90 percent of anything. So

1 any series of numbers, whether it's daily temperatures,  
2 random rolls of the dice, and shipments of all kinds of  
3 medications, his methodology was a one-size-fits-all  
4 methodology.

5 And Mr. Rafalski conceded that he views these exact  
6 same methodologies with equally astounding results in  
7 litigation in Ohio and New York. So there's nothing special  
8 or different about his analysis in Cabell and Huntington.

9 Now, let me come back to due diligence because that's  
10 something that the plaintiffs have tried to spend some time  
11 on. The only thing that the plaintiffs mentioned yesterday  
12 about Cardinal Health, Your Honor, the only thing was a  
13 reference to due diligence and Medicine Shoppe. So I want  
14 to spend a little bit of time going through that with you.

15 Mr. Rafalski admitted he obviously had not looked at  
16 the due diligence files in their entirety. And just to  
17 remind Your Honor of the testimony from Mr. Mone, Mr. Mone  
18 was asked about due diligence when he came to testify.

19 And as Mr. Mone testified, Cardinal Health did due  
20 diligence on every order that hit a threshold and did  
21 on-going due diligence on customers from Know Your Customer  
22 as well as site investigation.

23 Now, Cardinal has 34 -- or during this time period had  
24 34 customers in Cabell and Huntington. And, again, at trial  
25 and yesterday the plaintiffs have discussed essentially one,

1 Medicine Shoppe.

2 And I think they've essentially tried to allude that  
3 there was no due diligence done for Medicine Shoppe. But,  
4 Your Honor, this right here is the due diligence file for  
5 Medicine Shoppe that was produced to the plaintiffs. And  
6 this is P-42116 for the record.

7 This document has hundreds of pages of diligence all  
8 the way back to the questionnaire that Medicine Shoppe  
9 filled out back in 2008 when it became a customer of  
10 Cardinal.

11 Another thing that this file contains is several  
12 anti-diversion customer profiles. So when an order hits a  
13 threshold, Your Honor, Cardinal Health's anti-diversion team  
14 reviews the information that's shown here -- type of  
15 information that's shown here to determine whether to  
16 release the order or to report the order as suspicious.

17 And the type of information that they analyze and look  
18 at includes one of the things I mentioned earlier which is  
19 the overall controlled substance percentage to the, to the  
20 entire prescription percentage; the volume of particular  
21 categories of drugs; the number of previous threshold events  
22 that the customer has had, so basically their track record;  
23 and then their overall purchase data by month for that drug  
24 family.

25 In later periods under Mr. Cameron, for example, this

1 type of data was enhanced and different types of analytics  
2 were used. But there is multiple types of due diligence of  
3 this variety that is in the file. So it is astounding that  
4 the one thing that the plaintiffs point to is an unexplained  
5 two-word phrase in an email that says "black hole."

6 They didn't explain to you what that said or what that  
7 meant. They didn't call the person at trial who wrote that  
8 email. But what we do know about the Medicine Shoppe is  
9 that there is a long history of diligence on this customer.

10 Mr. Farrell told you yesterday that after the black  
11 hole email, nothing happened. That's wrong.

12 Right after that email, Cardinal Health immediately  
13 followed up with a full site investigation. And that's  
14 documented in the file. And Mr. Mone actually told us about  
15 that at trial. He said the black hole email was reviewed by  
16 him.

17 The anti-diversion team reviewed this investigative  
18 report, Your Honor, which is in the file and found no  
19 evidence of diversion.

20 Other site visits at Medicine Shoppe confirmed the same  
21 thing. There was a full investigative visit in December of  
22 that year and again in -- that was 2012, Your Honor. So  
23 they went back again that year. And then there was also a  
24 full investigative visit that's in the file for 2015 and  
25 2016. And each time, the investigators found no evidence of

1 diversion.

2 Now, we also heard from Jesse Kave who was Cardinal  
3 Health's sales representative. And he testified that he  
4 monitored his customers for signs of diversion. He called  
5 on Medicine Shoppe for 12 years, and he lived only a half an  
6 hour away from Medicine Shoppe.

7 He got to know the pharmacists there. He found them to  
8 be professional. And he did not have concerns about  
9 diversion which is a fact that he documented repeatedly.

10 Now, another witness that the plaintiffs didn't call  
11 but had under subpoena during the entirety of their case  
12 was, in fact, the representative from Medicine Shoppe. So  
13 we didn't get a chance to ultimately cross-examine that  
14 person, but the, the plaintiffs had the opportunity to bring  
15 that person in.

16 And as I stand here today, Your Honor, Medicine Shoppe  
17 remains a licensed pharmacy in good standing with the State  
18 of West Virginia as well as the DEA.

19 So, Your Honor, with respect to the Suspicious Order  
20 Monitoring System, to the extent that the plaintiffs even  
21 covered that type of information, there is just absolutely  
22 no evidence that Cardinal Health acted unreasonably in that  
23 context.

24 Let me shift over to causation, Your Honor.

25 The plaintiffs have to prove that they caused the

1 alleged harms, and here they cannot.

2 Now, as our briefing has covered with Your Honor,  
3 causation has two components; but for causation and  
4 proximate causation. And our position is that the  
5 plaintiffs have proven neither.

6 On the but for causation, or sometimes called cause in  
7 fact prong, plaintiffs have to show that the alleged harms  
8 would not have happened without Cardinal Health's alleged  
9 misconduct.

10 So they had to prove here, Your Honor, that if Cardinal  
11 Health had done something different, the problems in Cabell  
12 and Huntington never would have happened.

13 When they filed their brief on causation this weekend,  
14 they had no answer to the cause in fact argument that we  
15 raised. And they gave no answer to it in closing yesterday.  
16 They didn't even mention but for cause.

17 The bottom line is that the same number of opioid  
18 prescriptions would have been written and filled in Cabell  
19 and Huntington even if Cardinal Health had not existed.

20 Doctors, as we know, decide how much to prescribe. The  
21 DEA decided how many opioids would be available for  
22 dispensing.

23 Mr. McCann told us that there were 35 other  
24 distributors doing business in Cabell County. Our pharmacy  
25 customers could have ordered from any of them.

1           Mr. Rafalski told us he didn't know of a single  
2 instance where a distributor cut off the pharmacy and the  
3 pharmacy didn't just switch to a new distributor. Only the  
4 DEA can cut off a pharmacy.

5           So on the evidence that's before the Court, Your Honor,  
6 even if there had never been a Cardinal Health, doctors in  
7 Cabell County would have written the exact same number of  
8 prescriptions. Pharmacies would have filled them. They  
9 would have ordered the exact same amount of medications from  
10 distributors. And distributors would have shipped them.

11           If the same thing would have happened in the absence of  
12 our very existence, then by definition, there is no but for  
13 causation.

14           Now, they say we should have done more due diligence.  
15 But they have not shown you a single order that would have  
16 or should have been rejected if we had done more due  
17 diligence.

18           They say we should have sent more reports to the DEA.  
19 But the evidence shows that the DEA didn't even act on the  
20 reports we sent them already. And, so, this is a basic  
21 legal proposition, Your Honor. And it's not a proposition  
22 that is necessarily apparent in every case, but, but it is  
23 apparent in this one. They say we should have done certain  
24 things we didn't do, but they haven't proven that if we had  
25 done them that anything would have been different. And if



1 they cannot prove that, there is no liability for causation  
2 purposes.

3 Now let me shift over to proximate cause. And let me  
4 start with the standard for proximate cause.

5 Plaintiffs have to show the alleged harm is a direct  
6 consequence of the alleged conduct. And that's the test, as  
7 Your Honor knows, that Judge Copenhaver applied last year  
8 specifically in the context of the prescription opioid  
9 litigation, the *JCAHO* case. And as you know, he dismissed  
10 the case on 12(b)(6) grounds for lack of proximate cause.

11 Now, with respect to the Copenhaver case, we will  
12 address that case, Your Honor, more fully in our proposed  
13 conclusions of law. But one of the points that plaintiffs  
14 focused on is foreseeability. And foreseeability alone is  
15 not enough. It's one part of the analysis, but it's not the  
16 entire analysis.

17 And West Virginia law is clear that the Court has to  
18 find that the defendant is a direct, not a remote, cause.  
19 And that's what Judge Copenhaver said in the *Joint*  
20 *Commission* case. And Judge Chambers said the same thing in  
21 the *Teamsters* case from 2013.

22 Now, Your Honor asked yesterday how the *City of*  
23 *Charleston* case is different from this one. And we think  
24 it's the same. We don't view it to be different.

25 Mr. Majestro was asked a follow-up question on that or

1 answered a follow-up question on that. And Judge  
2 Copenhaver, to be clear, did not find that there would be  
3 proximate cause as it relates to distributors. He didn't  
4 make any finding as it relates to distributors.

5 But what he did say in a case about what caused the  
6 opioid epidemic was that the Joint Commission was too remote  
7 because of multiple actors in the chain, including criminal  
8 actors and doctors exercising their medical judgment.

9 And if this trial has established anything, Your Honor,  
10 it's that those facts are equally present here.

11 So after a full trial, plaintiffs have failed to prove  
12 their basic theory of causation.

13 Coming back to what their theory is, their theory is  
14 that Cardinal Health caused the volume of opioids that  
15 entered Cabell and, therefore, caused the diversion and  
16 misuse of the prescription opioids in Cabell and Huntington,  
17 and ultimately caused the abuse of heroin and fentanyl in  
18 this jurisdiction.

19 But they did not actually prove any of those things.  
20 So if we start with volume, everything I said about volume  
21 and reasonableness, Your Honor, applies equally to proximate  
22 cause.

23 But there's no evidence that in any way Cardinal Health  
24 caused the volume of prescription opioids that entered the  
25 market. As we've talked about, the volume comes from the

1 number of prescriptions doctors write and the upper limits  
2 that the DEA imposes in the form of quota. And Cardinal  
3 Health has no control over either one of those.

4 And as we're thinking about it, it's worth remembering  
5 what the plaintiffs claim about why the standard of care  
6 ultimately changed. And the plaintiffs in their complaint  
7 don't say it was the distributors who changed the standard  
8 of care. They say it was manufacturer marketing.

9 So looking at the admissions that are in the  
10 plaintiffs' complaint, the plaintiffs say manufacturer  
11 marketing defendants' deceptive marketing caused prescribing  
12 not only of their opioids, but of opioids as a class, to  
13 skyrocket.

14 Mayor Williams agreed that it was the manufacturers'  
15 deceptive marketing that caused, their word, caused the  
16 prescribing of opioids to skyrocket. And, of course, we  
17 already know that the city also blamed, in addition to the  
18 manufacturers, the Joint Commission for changing ultimately  
19 the standard of care.

20 The city said that the Joint Commission teamed with  
21 Purdue to cause the opioid crisis by pushing pain as the  
22 fifth vital sign and increasing prescribing. So that's  
23 prescribing.

24 There's also no proof, Your Honor, that we caused  
25 diversion or misuse. And, again, there are just too many

1 links in the causal chain.

2 First, you've got to have a state and federally  
3 licensed doctor prescribe the medication. Then you've got  
4 to have a state and federally licensed pharmacy dispense the  
5 medication. Then someone has to divert it. And then  
6 someone has to use it illegally.

7 So that prescribing link has nothing to do with us. We  
8 never see a prescription, Your Honor. Our pharmacy  
9 customers place bulk orders from us so they'll have an  
10 inventory to fill prescriptions they expect patients will  
11 bring to them in the future.

12 We have to way of knowing whether the medications in  
13 those orders will go to terminal cancer patients or  
14 post-surgical patients or injured coal miners. That's up to  
15 the doctors to decide.

16 Now, remember what Dr. Werthammer told us. He had sent  
17 an email to the Mayor and other leaders that said,  
18 "Unfortunately --" and this is from 2016. "Unfortunately,  
19 it was not big pharma who wrote the prescriptions. It was  
20 me and my colleagues. Joe."

21 And his colleague, Joseph Shapiro, Dr. Shapiro, who's  
22 the Dean of Marshall's medical school, wrote right back.  
23 "We had some help. Pain as the fifth vital sign comes to  
24 mind."

25 The medicine cabinet diversion that happens after the

1 medicine leaves the pharmacy isn't caused by anyone in the  
2 DEA regulated supply chain. Either the patient who gets the  
3 medication -- the patient either sells it or gives it away.  
4 And that's a crime. Someone comes along and steals it,  
5 either uses it or sells it, and that's a crime. And,  
6 finally, someone has to use the illegally diverted  
7 medication, and that is also a crime. And Cardinal Health  
8 can't stop any of that from happening.

9 Now, even Mr. Rafalski agreed that medicine cabinet  
10 diversion is the responsibility of the patient, not the  
11 distributor who supplies the patient's pharmacy and has no  
12 control.

13 Now, turning to illegal drugs, which has been a problem  
14 in Cabell and Huntington for a significant number of years,  
15 the plaintiffs have not proven we caused heroin and fentanyl  
16 abuse. Obviously, heroin and fentanyl, illicit fentanyl are  
17 distributed by drug traffickers, not Cardinal Health.

18 And the idea of holding us liable for the criminal  
19 conduct of drug dealers a decade after they last complained  
20 about anything happening with our Suspicious Order  
21 Monitoring Systems is completely and utterly remote.

22 Now, plaintiffs when they use the word "opioid" have  
23 been imprecise to say the least. They've used the term  
24 broadly. And they use it broadly generally to encompass  
25 illegal drugs.

1           So take, for example, Ms. Kearse spoke yesterday about  
2           the West Virginia outbreak report and featured that report  
3           in her closing. And that was one of Dr. Gupta's reports.

4           But that report, Your Honor, from 2016 was entirely  
5           about the string of overdoses in Huntington from  
6           fentanyl-laced heroin. It had nothing to do with  
7           prescription drugs.

8           Now, we heard testimony that Cabell County and  
9           Huntington have had an enormous problem with illegal drug  
10          traffickers. And there's a lot of that in the record and I  
11          imagine Mr. Hester will cover that.

12          But the city has admitted that the problem dates back  
13          to at least 2002 and that relates to economic cuts that were  
14          made in that time period.

15          Because of that knowledge and recognition about the  
16          prevalence of illegal drugs in Cabell and Huntington and  
17          those being the driving force behind substance abuse issues,  
18          the plaintiffs have tried to fill the hole that they have on  
19          causation with a gateway theory. And that's the idea that  
20          prescription opioid use causes the use of illegal opioids  
21          like heroin and fentanyl.

22          In the first instance, Your Honor, gateway is  
23          irrelevant to liability. Gateway does not show that  
24          Cardinal Health caused anyone to use heroin or fentanyl.  
25          And even if there is a gateway effect from the use of FDA

1 approved medication, the individual use of illegal drugs  
2 would be far too attenuated from our conduct and far too  
3 remote under the case law to establish liability.

4 But just so that the record is straight on gateway and  
5 the evidence that the Court heard, I just want to cover a  
6 few points on the gateway theory.

7 Your Honor has heard about the 80 percent number. The  
8 80 percent figure that plaintiffs throw around, Your Honor,  
9 is about illegal misuse or non-medical use of prescription  
10 opioids, not legal use.

11 So there's the Muhury study which says four out of five  
12 heroin users previously used prescription opioids. But as  
13 Dr. Gilligan explained, the Muhury study, which is the  
14 primary source that the plaintiffs point out, looked at  
15 prescription opioid misuse, not medical use, and it's only  
16 looking at people who use prescription opioids illegally.

17 Second, even among people who misuse prescription  
18 opioids, the percentage who transition to heroin is very  
19 low. And Dr. Gilligan and Dr. Keyes testified that the vast  
20 majority of people who misuse prescription opioids do not go  
21 on to use heroin. Only 3.6 percent of them do.

22 Third, the reality is that people who abuse drugs,  
23 abuse lots of them, not just one kind, so illegal drugs  
24 begets illegal drugs. And the Muhury study showed almost  
25 all illegal drug users have used a wide variety of drugs in

1 their past. And even Dr. Keyes agreed with that.

2 Dr. Gilligan also agreed with that. And if you look at  
3 his actual testimony on this issue, he said that people  
4 transition to heroin from all kind of drugs, cocaine, crack,  
5 marijuana and other drugs.

6 Now, Dr. Murphy. He said the research shows that some  
7 people are just simply prone to abuse drugs. And that's  
8 certainly consistent with everyone's life experience. They  
9 abuse whatever substance is available and often lots of  
10 different ones.

11 And Dr. Waller told us, the addiction specialist, why  
12 that happens. He said that all addictive substances have  
13 the same final common pathway in the brain and they all  
14 affect dopamine. So it's not a surprise that people with  
15 addiction will abuse multiple substances.

16 It's not about a gateway from one drug to another.  
17 It's an overall addiction problem, which is a point that  
18 Dr. Judith Feinberg, plaintiffs' expert on IV drug use,  
19 agreed to. And she called it a polysubstance opioid  
20 addiction problem. And she said further that the real  
21 problem of addiction lies in the social and economic fabric.

22 Stephanie Colston agreed. And she says that the  
23 country's not suffering from an opioid epidemic per se, but  
24 from a crisis of polysubstance use and substance use  
25 disorder.



1           Here's the fourth thing about gateway. The numbers  
2 show no link between prescription opioid distribution and  
3 illegal opioid overdose deaths.

4           So Dr. Murphy showed you this scatter chart. And  
5 literally the dots are all over the map. There is no trend.  
6 He analyzed the data and said not only is there no causal  
7 relationship, there's not even a correlation.

8           And he concluded that places, as an example, that have  
9 high shipments of prescription opioids did not necessarily  
10 have higher death rates from illegal opioids.

11           So the gateway theory is both irrelevant to liability  
12 and contradicted by the evidence.

13           Another piece of evidence, Your Honor, that there is no  
14 causation here outside of this litigation is that the  
15 plaintiff -- neither the plaintiff nor the state say that  
16 the distributors caused the opioid problem.

17           So for the past 10 years, one committee after another  
18 has studied this issue. And they've written report after  
19 report after report. And there's a stack of those reports  
20 in evidence at this point, Your Honor. And not one of them  
21 point to any misconduct by distributors as a cause of the  
22 opioid epidemic. And there are a number of reports that are  
23 in the record right now.

24           So you've got the city's 2011 drug market intervention  
25 report that blamed the problem on police budget cuts and the

1 influx of drug dealers.

2 And the city's 2015 strategic plan did the same thing.  
3 It had a prevention prong that focused on illegal drug  
4 dealers.

5 The 2016 Social Autopsy that we looked at with Dr.  
6 Gupta, I think Mr. Farrell said that yesterday -- yesterday  
7 said that it proves diversion. But it says nothing about  
8 distributors. The report focused on doctors and their  
9 prescribing. And 2016, of course, was the year that the CDC  
10 guidelines came out.

11 The city's 2017 strategic plan. In the prevention  
12 recommendation it focuses on drug dealers.

13 And the city's 2018 report to the National League of  
14 Cities, that's the one that pointed to the poor health. It  
15 doesn't say anything about distributors.

16 And then Dr. Gupta's 2018 opioid response plan. Like  
17 Dr. Gupta's other reports, these recommendations focused on  
18 prescribers.

19 To sum up on proximate cause, Your Honor, let me walk  
20 through the causal chain and walk you through what the  
21 theory would be.

22 So the plaintiffs' theory is that if a patient suffered  
23 pain and a licensed doctor prescribed FDA approved opioids  
24 for that pain and a licensed pharmacist dispensed them and  
25 the patient had leftovers in the medicine cabinet and

1 someone got their hands on those leftovers and used them or  
2 sold them and a tiny fraction of those people later used  
3 heroin or fentanyl, which came either from a drug cartel in  
4 Mexico or China or via a drug dealer from Detroit operating  
5 in Huntington, that down the chain Cardinal Health should be  
6 liable for filling a bulk order, a bulk order from the  
7 licensed pharmacy.

8 It is much too attenuated, the chain of events, and is  
9 a good reason that Judge Copenhaver invoked proximate cause  
10 to dismiss the city's case against the Joint Commission.  
11 And there's a good reason that Judge Chambers rejected -- or  
12 adopted the proximate cause argument in that particular case  
13 related to the Teamsters.

14 And Judge Chambers in that case cited a vast array of  
15 intervening events, including also, just like Judge  
16 Copenhaver, the intervening medical judgment of doctors.

17 Plaintiffs have no basis to distinguish those cases.  
18 And now that we've heard the evidence, the absence of  
19 proximate cause is even more glaring in this case.

20 Now, Your Honor, Mr. Hester is going to cover  
21 abatement, so I only want to make one point on abatement.  
22 And that's the threshold issue with respect to abatement.

23 And the briefing on this is, is in our papers. But as  
24 a threshold matter, Your Honor, a Federal Court sitting in  
25 equity does not have the power to award equitable relief if

1 there is an adequate remedy at law. And that's the rule  
2 from the *Sonner* case. More than 10 courts since 2020 have  
3 followed that case. And that by itself, Your Honor, is a  
4 dispositive issue.

5 Now, in their brief filed Sunday, which I'm sure Your  
6 Honor has not had a chance to read, the plaintiffs say that  
7 the *Sonner* rule doesn't apply to them because they're  
8 governmental plaintiffs. And that's their main response.  
9 But that is wrong.

10 The exception they cite for that proposition only  
11 applies to sovereign governments like the United States or  
12 the State of West Virginia, not cities or counties. So  
13 that's a critical issue, Your Honor, that, that we feel this  
14 Court ought to take a look at.

15 Your Honor, there is a vast disconnect between the  
16 evidence we've heard and what the plaintiffs say in this  
17 case. Huntington's efforts on the opioid problem have been  
18 successful and it has cast itself as the City of Solutions.

19 And we've heard a lot of testimony about the financial  
20 resources that are already available to the city and the  
21 county, including Medicaid funding for treatment. We've  
22 heard about federal funding for substance abuse response.  
23 And, of course, there are cases other than this one that  
24 plaintiffs continue to pursue against manufacturers and  
25 others.

1 But what matters in this courtroom is not any of that.  
2 It matters what they have proven. Not one actual order we  
3 should have shipped has been proven in this courtroom. They  
4 have failed to prove that one actual customer should not  
5 have been shipped to.

6 They have failed to prove that one actual customer was  
7 diverting or that one actual customer has even been  
8 disciplined or lost their license.

9 There's been no failure of due diligence. There's not  
10 one prescription that was written because of something  
11 Cardinal Health did. And prescriptions being written based  
12 on the standard of care that the entire medical community  
13 was following, including the State of West Virginia, cannot  
14 be a basis for a finding of unreasonableness.

15 There's been a total failure of the plaintiffs' case on  
16 every disputed issue, Your Honor, and it compels a finding  
17 for the defense.

18 We are extremely grateful for the time and attention  
19 you have given to us in this matter, Your Honor, and the  
20 courtesies that you have given to all of us. Thank you for  
21 your time.

22 THE COURT: Thank you.

23 It's 10 after 11:00. When do you want to come back?

24 Mr. Hester, you don't want to start your argument now,  
25 do you?

1 MR. HESTER: Well, I'd rather not split it, Your  
2 Honor. And I can imagine it will make for a very late  
3 lunch. So I'm perfectly happy to come back whenever the  
4 Court wants after a lunch break.

5 THE COURT: I always consult Ms. Skinner on  
6 important matters like this one.

7 How about 12:30? Is that okay with everybody? All  
8 right. I'll see you at 12:30.

9 MR. HESTER: Thank you, Your Honor.

10 (Recess taken at 11:10 a.m.)

11 THE COURT: You may proceed, Mr. Hester.

12 MR. HESTER: Good afternoon, Your Honor.

13 THE COURT: Good afternoon, sir.

14 MR. HESTER: The plaintiffs' claim is foreclosed  
15 by the law and it's unsupported by the record evidence.  
16 This conclusion follows from five overarching points that  
17 I'm going to briefly summarize and then I'll discuss in more  
18 depth.

19 The first point is that the plaintiffs cannot establish  
20 proximate causation here for two central reasons. First,  
21 the increased volume of prescription opioids in the  
22 Cabell-Huntington community was driven by doctors' good  
23 faith prescribing decisions based on prevailing standards of  
24 care.

25 And, second, the plaintiffs' claimed harm in this case

1 is based overwhelmingly on diversion from the medicine  
2 cabinet or people's homes after opioids are prescribed and  
3 dispensed. Distributors are not responsible for this  
4 diversion and cannot control it, as the plaintiffs' own  
5 expert admitted.

6 So these intervening decisions of doctors who determine  
7 the volume of opioids and the intervening criminal acts of  
8 multiple actors who diverted opioids after they were  
9 prescribed defeats proximate causation on this record.

10 The second point. The plaintiffs cannot establish a  
11 public nuisance on this record where doctors were  
12 prescribing medicines in good faith to treat an important  
13 medical need and distributors had no ability to second-guess  
14 those prescribing decisions.

15 The third point. McKesson's shipments into  
16 Cabell-Huntington did not cause harm and plaintiffs have no  
17 evidence of improper conduct or diversion by any of  
18 McKesson's customers in Cabell-Huntington. Likewise, the  
19 plaintiffs were not harmed by any issues relating to  
20 suspicious order reporting because distributors always  
21 blocked orders likely to be diverted and distributors  
22 blocked all suspicious orders by no later than 2008.  
23 Blocked orders cannot give rise to diversion.

24 Fourth point. The current drug crisis in  
25 Cabell-Huntington is a crisis of heroin and illicit fentanyl

1 abuse and the abuse of other illegal drugs. The plaintiffs  
2 cannot establish proximate causation between the  
3 distribution of prescription opioids and subsequent harms  
4 from illegal drugs such as heroin and illicit fentanyl.

5 And the fifth point, the plaintiffs' evidence  
6 supporting their requested abatement remedy is entirely  
7 flawed and cannot support their claim for relief.

8 We said in our opening, Your Honor, that our case does  
9 not turn on denying the existence of an opioid epidemic, and  
10 it does not, but the record establishes that the plaintiffs  
11 have failed to prove their case in terms of causation, the  
12 existence of a public nuisance, and remedy. The case law,  
13 therefore, forecloses their claim.

14 So, let me now turn to some of these issues in more  
15 detail and I want to start with proximate causation. The  
16 requirement of a direct causal relationship between the  
17 alleged wrongdoing and the claimed harm.

18 Mr. Farrell's verdict form that he discussed yesterday  
19 never addressed this critical linkage between the  
20 defendants' conduct and the claimed injury and, in  
21 particular, the evidence reflects that proximate causation  
22 is defeated here by the prescribing decisions of doctors and  
23 the multiple criminal acts involved in diversion of opioids  
24 after they're prescribed.

25 This is not a question of pointing blame at others.



1 It's not a question of pointing fingers at others. It's  
2 rather a fundamental legal bar to the plaintiffs' claim.

3 The plaintiffs stake their case on the volume of  
4 prescription opioids that distributors shipped into  
5 Cabell-Huntington. The Court heard about this yesterday in  
6 Mr. Farrell's closing, 81 million pills, and they want the  
7 Court to conclude that the volume of shipments standing  
8 alone are sufficient to hold defendants liable for the  
9 entire opioid crisis in Cabell-Huntington.

10 But Mr. Farrell went 90 minutes into his closing before  
11 mentioning doctors and Ms. Kearse never even mentioned the  
12 central role of doctors in prescribing these medicines.

13 Now, the Court has already heard some of this before in  
14 the other two closings. Not surprisingly, because these are  
15 central issues in the case, but I want to build these  
16 building blocks of the legal conclusions by pointing to some  
17 of these critical facts that frame up the legal conclusion.

18 First of all, the evidence is conclusive and undisputed  
19 that prescribing by doctors and other medical professionals  
20 drove the volume of pills sold in Cabell-Huntington.

21 Dr. Gupta made the point very clearly in his opioid  
22 response plan. He said a critical factor fueling the  
23 national opioid epidemic is the rapid rise in opioid  
24 prescriptions. And he noted that West Virginia has  
25 experienced some of the highest rates of opioid prescribing

1 in the nation.

2 Dr. Keyes said that the high volume of opioid  
3 prescriptions that doctors were writing became the  
4 foundation for the overall expansion of opioid supply.

5 And Mr. Rafalski agreed when he was asked, there was no  
6 other way for his charts to increase, no other way for that  
7 hill to go up, for that hill to climb, without  
8 prescriptions.

9 So, if the volume of prescription opioids was  
10 excessive as the plaintiffs claim, this was the result of  
11 medical judgments made by doctors and changes in the  
12 standard of care, not actions taken by distributors.

13 Dr. Gupta made the point very clearly. He said you'd  
14 easily write several more days of prescriptions than you  
15 would require. He referred to a culture of attempting to  
16 reduce pain from a scale of whatever to zero for every West  
17 Virginian and he said that was the culture. That was the  
18 education. That was the influence. That was their  
19 understanding.

20 Distributors responded to what doctors were  
21 prescribing, but they did not decide the quantity of  
22 prescription pills. That was decided by doctors based on  
23 medical judgment.

24 Dr. Murphy, the University of Chicago economist, made  
25 the point very clearly. He said the amount that doctors

1 distribute -- the amount that distributors distribute is  
2 determined by the prescribing behavior and he said it's the  
3 prescribing behavior that determines the amount.

4 And this responds to the point that the Court asked  
5 about previously. Could supply drive demand? Not in this  
6 industry. Not in this industry where prescriptions are  
7 needed in order for any pills to leave a pharmacy. Clearly,  
8 as Dr. Murphy said, demand by the doctors working together  
9 with patients is what drove the level of volume.

10 Mr. Rannazzisi made this point very, very clearly. He  
11 said, no, supply is not what drives demand. Supply is not  
12 what drives demand. That's one of the plaintiffs' own  
13 experts.

14 And there was discussion previously today of the  
15 calculations by Ms. Lacey Keller, who determined that the  
16 average number of pills prescribed per person in Cabell  
17 County from 2006 to 2014 were 141.2 pills per person.

18 Looking at the shipment data from Dr. McCann based on  
19 ARCOS the shipment data showed 142 pills per person. This  
20 is conclusive evidence on the point that distributors only  
21 shipped what doctors prescribed. There's no other  
22 explanation for this observation. Clearly, distributors  
23 were responding to the prescription behavior of doctors.

24 Now, the Court asked previously today how does one  
25 decide on the reasonableness of a level of prescriptions?

1 Well, the reason -- or the reasonableness of the level of  
2 shipments, it's set by the doctor prescribing. Doctors made  
3 the judgment as to how many pills were needed. Distributors  
4 were responding to those judgments. That determines the  
5 reasonableness in this marketplace.

6 The evidence is also conclusive that this prescribing  
7 of opioids was overwhelmingly in good faith and the Court  
8 has heard some of this already, but just to highlight it,  
9 the DEA concluded nearly every prescription issued for  
10 prescription opioids is for a, quote, "legitimate medical  
11 purpose". Mr. Rannazzisi and Mr. Rafalski both said that 99  
12 percent of the doctors were prescribing legitimately and Dr.  
13 Keyes said the overwhelming majority of doctors prescribed  
14 in good faith.

15 Mayor Williams of the City of Huntington likewise --  
16 likewise testified that the vast majority of doctors in  
17 Cabell County and Huntington thought they were prescribing  
18 opioids appropriately.

19 And, furthermore, Dr. Keyes testified that pill mill  
20 doctors do not explain in any significant way the expansion  
21 of opioid supply or harms.

22 Not a single witness in this case said the distributors  
23 had anything to do with doctors' prescribing decisions or  
24 with the changes in the standard of care that the Court has  
25 heard about. And the evidence is also conclusive and

1 overwhelming that distributors cannot second-guess these  
2 good faith prescribing decisions by doctors.

3 This was stated very clearly by Mr. Rafalski and Mr.  
4 Rannazzisi. Mr. Rafalski said the DEA does not expect  
5 distributors to second-guess prescribers and Mr. Rannazzisi  
6 said a distributor cannot make the determination if a  
7 controlled substance is medically necessary and he said  
8 we've never asked a distributor to do that.

9 So, in hindsight, Your Honor, many in the medical  
10 community now believe that doctors previously prescribed too  
11 many pills, but doctors were asking under the then  
12 prevailing standards of care as they evolved and the  
13 decisions were for the doctors to make, not distributors.

14 So, let's turn to the second point. We've just  
15 discussed this first causal gap in the plaintiffs' evidence  
16 based on doctor prescribing. That is a core causal gap.

17 But there's a second one, as well. A second causal gap  
18 is that the harms created by diversion are caused by  
19 multiple criminal acts after opioids are prescribed. The  
20 only evidence of diversion in this record is when unused  
21 prescription opioids were diverted by family, or friends, or  
22 were sold.

23 Again, Dr. Keyes made this point very clearly. Quote,  
24 "Pervasive over-prescribing resulted in unused prescribed  
25 opioid medications diverted for monetary value, bartered, or

1 for no cost."

2 Stated, as well, very clearly again in the paper that's  
3 in evidence by Dr. Compton, the Deputy Director of the  
4 National Institute on Drug Abuse, where he said as a result  
5 of these shifts in practice, referring to the shifts in  
6 practice in prescribing behavior, quote, "unused pills  
7 became increasingly available for diversion and misuse".  
8 Unused pills, a key point.

9 And the plaintiffs make their same point, make the same  
10 point, in their abatement brief that they filed just this  
11 past weekend. As the plaintiffs said, as the volume of  
12 drugs increase, drugs will be kept in patient's homes where  
13 they may be diverted. This is the heart of the plaintiffs'  
14 case that these unused prescription opioids led to harms as  
15 the pills were diverted from medical use.

16 Dr. Gupta again made the point very clearly. He said  
17 so instead of three days of prescription, you write for  
18 30 days. That's a problem. And he said that was a common  
19 mistake in the medical profession.

20 So, in other words, doctors made good faith decisions  
21 to prescribe opioids, but they prescribed too many pills  
22 that were left over or not needed and then the unused pills  
23 were diverted out of the medicine cabinet out of homes and  
24 led to this pattern of abuse and addiction. All of this  
25 happens after the pills leave the pharmacy and are being

1 used or abused.

2 Dr. Keyes again said that when she was talking about  
3 exposure and supply, she was talking about opioids that are  
4 out in the community. That's the issue. They're out in the  
5 community. They've left the pharmacy. They've been  
6 dispensed. This is medicine cabinet diversion.

7 The pills have been prescribed by a doctor, dispensed  
8 by a pharmacy, and they're out in the community, and they're  
9 being diverted after the pills left the Closed System of  
10 Distribution, after they left the closed system.

11 There is no evidence in this record of pills leaving  
12 the pharmacy shelf without a prescription and the evidence  
13 confirms that distributors have no control over what happens  
14 to pills once they leave the pharmacy.

15 Mr. Rannazzisi -- I'm sorry. Mr. Rafalski said it very  
16 clearly. Distributors have no control over what happens at  
17 that point after the pills leave the pharmacy and, in  
18 particular, there's no way a distributor could control how  
19 many days of pills a doctor decides to write for a  
20 particular prescription.

21 Recall what Dr. Gupta said. They were writing for  
22 30 days when only three were needed. The distributor  
23 couldn't possibly control for that, but that's the major  
24 source of the unused pills that were then diverted. Or a  
25 doctor's decision in the first place that a prescription

1 opioid is the appropriate treatment for a patient in pain.  
2 Distributors don't control that.

3 So, in other words, what we're seeing is diversion that  
4 occurs when distributors do their job exactly as they're  
5 supposed to. The doctor prescribes the pills and then the  
6 patient sells, or gives them away, or the patient misuses  
7 the pills after they're prescribed.

8 Mr. Rannazzisi said this very clearly. He agreed the  
9 distributor does what they're supposed to do. The  
10 distributor does what they're supposed to do and the pills  
11 get sold, stolen, or given away.

12 So, medicine cabinet diversion is not something  
13 distributors create and it's not something they control.  
14 Medicine cabinet diversion involves intervening criminal  
15 conduct of the people who divert the pills to illicit uses  
16 and the people who illicitly use those pills without a  
17 prescription. This all happens outside the closed system  
18 after the prescription opioids leave the pharmacy.

19 So, let's put these two points together. Given the  
20 undisputed and overwhelming evidence that prescribing  
21 behavior drove the volume and given the undisputed and  
22 overwhelming evidence that medicine cabinet diversion is  
23 what caused the alleged harm, plaintiffs cannot establish  
24 proximate causation.

25 The guiding legal standard is found in *City of*



1     *Charleston* and *Employer Teamsters*, two cases from this  
2     district dismissing tort claims under West Virginia law for  
3     lack of proximate causation. As reflected in the quotations  
4     on the slide here, those decisions establish that there must  
5     be a direct relation between the claimed harm and the  
6     wrongful conduct. Both cases said the same thing, the  
7     necessity of distinguishing the direct consequences in a  
8     closed causal chain.

9             And, in particular, both decisions highlighted that  
10    doctors intervening and prescribing decisions and medical  
11    judgments defeated proximate causation under West Virginia  
12    law. And I want to highlight in particular this language  
13    from both of these cases, *City of Charleston* saying, "No  
14    injury would occur unless the physician proceeded to  
15    unnecessarily prescribe opioid treatments." That's Dr.  
16    Gupta's point, prescribing 30 days when three days were  
17    warranted.

18            And then *Employer Teamsters* which referred to the vast  
19    array of intervening events including, quote, "the  
20    independent medical judgment of doctors".

21            This record presents exactly the same issue, exactly  
22    the same issue. Dr. Keyes made the point explicitly. She  
23    said that without doctor prescribing there would be no  
24    opioid crisis. There would be no harm. She said her view  
25    is the opioid crisis would not have occurred if prescribing

1       opioids had not become standard practice. Would not have  
2       occurred.

3               *City of Charleston* found there could not be proximate  
4       causation where, quote, "no injury would have occurred",  
5       that's a quote from the case, without a doctor's  
6       prescription and that's exactly what Dr. Keyes says in this  
7       statement that's in the slide here. Her testimony fits  
8       precisely within the test established by *City of Charleston*.

9               Both decisions, both *City of Charleston* and *Employer*  
10      *Teamsters*, also highlighted other intervening acts,  
11      including, in particular, criminal conduct that defeated  
12      proximate causation. Both cases referred to many  
13      intervening causes. *City of Charleston* referred to  
14      including criminal actions of third parties.

15              Again, this record presents exactly the same issue.  
16      Exactly. There would be no harm without medicine cabinet  
17      diversion, as we've discussed, which involves multiple  
18      criminal acts after the pills are prescribed and dispensed.  
19      Diversion by family, friends, drug dealers, misuse, or  
20      subsequent illegal drug use.

21              These acts of diversion are crimes and these multiple  
22      criminal acts likewise defeat proximate causation under *City*  
23      *of Charleston* and *Employer Teamsters*. These cases set it  
24      out very clearly. It's the precise same issue.

25              Now, Mr. Majestro said yesterday that *City of*

1     *Charleston* distinguished distributors from the defendants in  
2     that case. And the defendant in that case, as the Court  
3     will recall, was the Joint Commission, which is the  
4     accrediting organization that developed the concept of pain  
5     as the fifth vital sign. We've heard a lot about that  
6     through nine or ten weeks of evidence.

7             But all Judge Copenhaver said is that the Joint  
8     Commission was even further removed in the causal change  
9     than distributors. He did not hold or suggest that  
10    proximate causation exists as to distributors. That wasn't  
11    the issue that was before him. He concluded that the Joint  
12    Commission was further removed.

13            But the same independent actors, the same independent  
14    actors whose intervening conduct defeated a showing of  
15    proximate causation in the *City of Charleston*; namely,  
16    doctors and criminal actors, also defeat proximate causation  
17    here. If anything, the Joint Commission had a far more  
18    direct role than distributors in prescribing behavior  
19    because, of course, the Joint Commission drove the  
20    development of pain as the fifth vital sign.

21            The Court's heard extensive evidence on how important  
22    that was in expanding the use of prescription opioids to  
23    treat pain and distributors had nothing to do with that.  
24    Yet, Judge Copenhaver said that was not enough to establish  
25    proximate causation.

1           It also bears emphasis that *City of Charleston* was  
2           decided on a motion to dismiss. This Court now has the  
3           benefit of a full record that demonstrates the absence of  
4           proximate causation on the record that I've just summarized  
5           for the Court.

6           Now, the plaintiffs have said in multiple briefs in  
7           this case that proximate causation depends solely on  
8           foreseeability, but that is not West Virginia law.  
9           Remoteness is clearly a component, a component of proximate  
10          causation, under West Virginia law. Foreseeability is also  
11          a component. They're both elements of the test of proximate  
12          causation.

13          And we see that very clearly in the *City of Charleston*  
14          case which referred both to foreseeability and remoteness at  
15          different passages in that opinion. As the Court assessed  
16          proximate causation, the Court looked at foreseeability. It  
17          then evaluated remoteness. Both elements had to be  
18          evaluated under West Virginia law.

19          And it bears emphasis that *City of Charleston* and  
20          *Employer Teamsters* apply this remoteness standard to reject  
21          West Virginia tort claims. The plaintiffs have suggested  
22          that these cases are not applying West Virginia law, but  
23          that's just wrong. They're applying the remoteness standard  
24          found in West Virginia law and citing to West Virginia state  
25          cases for that authority.

1           So, here, we have too many independent third-party  
2 actors standing between the distributors' conduct and the  
3 alleged harm. Doctor prescribing, that by itself is enough  
4 to defeat proximate causation, but we also have multiple  
5 criminal acts thereafter involved in this medicine cabinet  
6 diversion.

7           Now, plaintiffs have also blurred this issue of  
8 causation by suggesting that joint and several liability  
9 saves them on the issue of proximate causation, somehow that  
10 that avoids the problem they face, but that's wrong for two  
11 reasons.

12           First of all, joint and several liability does not  
13 apply here. The Court has previously held that the West  
14 Virginia apportionment statute does not apply, but that's  
15 not a holding that liability is joint and several.

16           And I put up on this slide the *Farley* case, a 1920 West  
17 Virginia Supreme Court case that's been cited on a number of  
18 occasions more recently, and the *Farley* case states the  
19 general rule, that tortfeasors acting independently are not  
20 jointly liable.

21           And it's notable to look at the facts of *Farley*.  
22 *Farley* involved the pollution of a stream by multiple coal  
23 companies and the West Virginia Supreme Court held that  
24 because those coal companies were acting separately and  
25 independently, they were not jointly liable even though

1 their alleged wrongful acts were quite similar and caused  
2 similar injury. In other words, all of the coal companies  
3 were putting residue, coal residue, into the same stream at  
4 around the same time but, nonetheless, because they were  
5 acting independently, joint and several liability does not  
6 apply, did not apply.

7 But even assuming that there's joint and several  
8 liability, that does not answer the requirement to show  
9 proximate causation. It's a separate question from joint  
10 and several liability and, as we've just discussed,  
11 proximate causation defeats the plaintiffs' claims under the  
12 holdings and the reasoning of *City of Charleston* and  
13 *Employer Teamsters*.

14 These two cases of this district set the framework.  
15 They answer the same legal issue. They address the same  
16 proximate causation issue now before the Court.

17 THE COURT: Do you know what the subsequent  
18 history of either one of those cases was?

19 MR. HESTER: On *Employer Teamsters* and *City of*  
20 *Charleston*, Your Honor?

21 THE COURT: Yes.

22 MR. HESTER: So, as I understand it, *City of*  
23 *Charleston*, there is a motion to amend the pleadings that's  
24 been pending for over a year, I believe, and in *Employer*  
25 *Teamsters*, I believe there was no appeal.

1 THE COURT: Okay.

2 MR. HESTER: So, given this overwhelming evidence  
3 that shipments were in response to doctors' prescribing  
4 decisions, the plaintiffs cannot establish a public nuisance  
5 and I want to underscore that. They cannot establish a  
6 public nuisance on this record.

7 And the record evidence establishes that the FDA  
8 approved prescription opioids for the treatment of pain with  
9 specific labeling warnings that highlighted both the risks  
10 and the benefits of these medicines.

11 And the Court will recall the testimony of Dr.  
12 Gilligan, who talked about black box warnings, noting that  
13 that was important where the FDA saw a serious specific risk  
14 that it wanted to cull out for doctors. That's what the FDA  
15 did. They identified risks and benefits for doctors and  
16 approved these drugs.

17 We also have the clear evidence that the DEA  
18 continually approved and expanded the quotas for these  
19 medicines based on its assessment in consultation with the  
20 FDA of the legitimate medical needs of the United States.

21 And that's a very important point again, the DEA making  
22 the judgment that the volume of prescription opioids in this  
23 country should properly increase in order to meet the  
24 medical needs of the United States and it did so in  
25 consultation with the FDA.

1           Mr. Farrell said yesterday that a volume of pills could  
2           be per se unreasonable. That cannot be right. The DEA sets  
3           quotas. The DEA permits the production and shipment of this  
4           volume of pills. It cannot possibly be correct to call that  
5           volume of pills per se unreasonable when the DEA, the agency  
6           charged with the responsibility, has decided that this  
7           volume of pills is necessary to meet the legitimate medical  
8           needs of the United States.

9           We've also heard quite a bit about the national medical  
10          community that urged much greater attention to the  
11          importance of treating pain over a 20-year period or more  
12          and also urged much greater use of prescription opioids.

13          We've also heard extensive testimony and discussion  
14          over the last two days about these standards issued by the  
15          West Virginia Board of Medicine; again, highlighting that  
16          doctors should be more attentive to treating pain and should  
17          be using prescription opioids to treat pain. This explicit  
18          encouragement from the West Virginia Board of Medicine is  
19          extremely important when we're talking about prescribing  
20          practices in West Virginia.

21          And we've quoted on this slide the testimony from Dr.  
22          Gupta who said, quote, "A doctor practicing in West Virginia  
23          should seek to follow the guidelines and policy statements  
24          that are issued by the Board of Medicine." So, here we have  
25          it, the Board of Medicine encouraging the use of opioids and



1 Dr. Gupta saying doctors are expected to adhere to that  
2 guidance.

3 So, when we put these points together we have the  
4 medical community and the key regulators, doctors, the Board  
5 of Medicine, FDA, DEA, the Joint Commission that accredits  
6 healthcare facilities, and others, they authorized, they  
7 directed, they encouraged the use of these medicines for  
8 treating pain.

9 And even today, even after all this attention that's  
10 been given to prescription opioids over the last decade or  
11 more, opioids continue to be recommended and approved and  
12 they're extensively prescribed even today for treating pain.

13 So, given the uncontroverted evidence of these  
14 judgments by doctors, the medical community, and key  
15 regulators, the record forecloses a public nuisance claim  
16 against distributors for supplying the medicines that  
17 doctors prescribed.

18 Under West Virginia law conduct which the public  
19 convenience imperatively demands cannot be a public  
20 nuisance. That's the *Pope v. Edward M. Rude* case.

21 Put another way, under the Restatement formulation of a  
22 public nuisance the distribution of a medicine to support  
23 the medical needs of patients as determined by doctor  
24 prescribing cannot be deemed an unreasonable interference  
25 with a right common to the public.

1           So, under either formulation we submit that this  
2           conduct cannot meet the standards for public nuisance.  
3           Distribution of these medicines is a critical service needed  
4           to support the medical judgments of doctors and to provide  
5           pain medicine to their patients.

6           Mr. Rannazzisi made this important point very clearly.  
7           He said he agreed that it's, quote, "vital that an adequate  
8           and uninterrupted supply of pharmaceutical controlled  
9           substances be available for effective patient care", a very  
10          important statement that bears directly on this question of  
11          a public nuisance.

12          We've already discussed the evidence that the  
13          overwhelming majority of prescriptions were written in good  
14          faith and that distributors only shipped what doctors  
15          prescribed. So, it follows that the overwhelming majority  
16          of shipments were necessary, were necessary, to respond to  
17          the good faith prescribing decisions of doctors.

18          Now, let's look at it the other way around. The  
19          implication that distributors of medical products should not  
20          distribute medicines that doctors are prescribing has  
21          profound and very risky implications. It cannot be what  
22          public nuisance law is intended to do. It would force  
23          distributors to second-guess doctors' prescribing decisions  
24          and precisely what the evidence reflects they cannot do.

25          And, as Mr. Rannazzisi acknowledged, the public health

1 would be injured if distributors did not ship medicines that  
2 doctors prescribed. As he said, it's a public health  
3 concern when pharmacies cannot dispense legitimate  
4 pharmaceutical controlled substances.

5 The idea that this should be a public nuisance would  
6 turn the law of public nuisance upside down. It would  
7 preclude or penalize legitimate activity taken in response  
8 to legitimate medical judgments made in good faith under  
9 prevailing standards of care.

10 This same theory of public nuisance could apply to the  
11 Smithfield ham example that the Court raised during the Rule  
12 52 arguments, a product with legitimate benefits and  
13 legitimate uses that also has adverse health effects. As  
14 the Court noted, ham contributes to obesity. At least some  
15 people say it does. And to public health problems.

16 But that is not a public nuisance claim because  
17 virtually all products have risks alongside the benefits and  
18 this is particularly true for medicines, which always have  
19 risks and benefits. That's what doctors weigh when they  
20 prescribe them. And that's what the regulators weigh when  
21 they approve and permit products, medicinal products, to be  
22 in the marketplace.

23 So, it was one thing for the plaintiffs to plead a  
24 claim of public nuisance. As the plaintiffs noted to the  
25 Court, many courts have denied motions to dismiss public

1 nuisance claims and we understand that at the motion to  
2 dismiss phase, but we now have a full evidentiary record,  
3 the first one in the country involving distributors of  
4 prescription opioids. And the record we've just discussed  
5 demonstrates why this cannot be a public nuisance.

6 Mr. Farrell said in the Rule 52 arguments that they  
7 brought this public nuisance case, quote, "rather than  
8 bringing 8,000 personal injury cases". That demonstrates  
9 precisely why this is not a proper public nuisance claim.  
10 It's an amalgamation of potential personal injury cases,  
11 each one of which would present its own unique factual  
12 pattern.

13 And there's already a well-developed body of product  
14 liability law that applies where individuals are injured or  
15 claim injury from a product. Public nuisance law does not  
16 fit this sort of claim.

17 And we see that reflected very clearly in the Third  
18 Restatement of Torts, which says that mass harms caused by  
19 dangerous products are better addressed through the law of  
20 product liability.

21 THE COURT: Could the plaintiffs have brought a  
22 class action on behalf of the -- of the 8,000 people who  
23 were involved here?

24 MR. HESTER: I would think so, Your Honor, subject  
25 to resolution of any class action issues around commonality

1 and the like, but one could imagine that there still would  
2 be a theory of common -- common injury or common factual and  
3 legal issues that would suffuse that kind of a class action,  
4 I would think. I haven't looked at it that carefully.

5 But I think the point, is we have -- it's effectively a  
6 products-related claim claiming injury and seeking treatment  
7 for the injuries from the use of opioids. It feels like a  
8 classic concept of a products liability claim.

9 THE COURT: I think about the asbestos cases and  
10 there were thousands of cases, but there were individual  
11 plaintiffs, if I remember that correctly.

12 MR. HESTER: That's right, Your Honor, and that is  
13 the way those cases were resolved.

14 And as the Restatement says, quote, "The common law of  
15 public nuisance is an inept vehicle for these kinds of  
16 products claims."

17 And we see this stated very clearly in this *State v.*  
18 *Lead Industries* case, one of the -- one of the lead paint  
19 cases in a very thoughtful decision issued by the Rhode  
20 Island Supreme Court where the Court said, first, a public  
21 right is more than an aggregate of private rights by a large  
22 number of injured people. And the Court also said that the  
23 manufacture and distribution of products rarely, if ever,  
24 causes a violation of a public right that would support a  
25 public nuisance claim.

1           And this gets, Your Honor, to some of the cases that I  
2           think you just alluded to. Consistent with the reasoning  
3           that we've just discussed, a wide range of cases, from lead  
4           paint, to asbestos, to handguns, and many others, have  
5           recognized that public nuisance does not apply to what is  
6           essentially an amalgamation of personal injury claims.

7           And we've quoted some of the language here.

8           "Law of public nuisance never before has been applied  
9           to products, however harmful."

10          "Nuisance would become a monster that would devour in  
11          one gulp the entire law of tort."

12          "So broad and undefined that the presence of any  
13          potentially dangerous instrumentality could be deemed to  
14          threaten it" and so forth.

15          There are a lot of cases that follow this same line of  
16          reasoning and that have recognized the inherent problems  
17          presented when we are talking about applying public nuisance  
18          to products.

19          The Smithfield ham example was a good one. I think  
20          medical products are even better. Because they're  
21          prescribed by doctors to meet a medical need, there's an  
22          intervening judgment that these are important for a medical  
23          purpose and that's -- should, in my view, be the paradigm of  
24          a case that doesn't extend to product -- to a nuisance  
25          theory.

1           Of course, any medicine, any prescription medicine, has  
2 risks and benefits, but when doctors weigh the risks and  
3 benefits and prescribe a medicine in good faith to treat  
4 pain, the record demonstrates why it is vital that patients  
5 have access to that medicine because the implication of a  
6 nuisance theory here would be patients would have less  
7 access to medicine that doctors are prescribing to treat  
8 pain.

9           And the record demonstrates why it would be dangerous  
10 and, in fact, entirely unworkable to suggest that  
11 distributors should be placed in the position of  
12 second-guessing the medical judgments of doctors by refusing  
13 to ship what doctors are prescribing.

14           So, that gets us through public nuisance. Let's turn  
15 now to discuss the evidence of McKesson's distributions in  
16 Cabell-Huntington.

17           This exposes another fundamental gap in the plaintiffs'  
18 case against McKesson. They have no evidence of diversion  
19 by any of McKesson's customers in Cabell-Huntington. They  
20 have no evidence of any improper activity by any of  
21 McKesson's customers in Cabell-Huntington. They have no  
22 evidence that any of McKesson's shipments into  
23 Cabell-Huntington were improper or unlawful. And they have  
24 no evidence that any of McKesson's shipments into  
25 Cabell-Huntington caused harm.

1           Now, the plaintiffs repeatedly mentioned 81 million  
2 pills yesterday in their closings, but McKesson did not  
3 distribute 81 million pills in Cabell-Huntington. In fact,  
4 if we look at the data, 76 percent of McKesson's  
5 distributions in Cabell-Huntington went to the VA Hospital.

6           And the plaintiffs do not contest those shipments to  
7 the VA. In fact, they don't allege that the VA shipments  
8 were excessive. They excluded the VA shipments from their  
9 analysis. They presented no evidence of diversion from the  
10 VA shipments. No evidence of any harm from the VA  
11 shipments.

12           THE COURT: But there wasn't anything about the VA  
13 situation that made the possibility for diversion there much  
14 different than non-VA pills, was there?

15           MR. HESTER: Well, it's -- the record is entirely  
16 silent on it, Your Honor, and the plaintiffs certainly  
17 presented no evidence of any diversion from VA shipments.

18           And the point I wanted to highlight here in particular,  
19 two of the plaintiffs' experts explained they were not  
20 looking at the VA. So, Mr. -- Dr. McCann excluded the VA  
21 summaries from his analysis.

22           But then, if you look at Mr. Rafalski's statement on  
23 the right-hand side, he said the diversion is occurring at  
24 the retail pharmacy level. And so, it wouldn't have been,  
25 as he said, prudent to include a hospital in the analysis.



1           So, Mr. Rafalski almost pointed it the other way, Your  
2           Honor, saying that he didn't think it was appropriate to  
3           look at the VA shipments in evaluating diversion but,  
4           certainly, the plaintiffs presented no evidence at all, made  
5           no --

6           THE COURT: I'm puzzled by this. It seems like,  
7           you know, you go into the hospital and you have surgery and  
8           they give you a bottle of pills to take home with you. I  
9           don't see that as any different than picking them up at the  
10          pharmacy.

11          MR. HESTER: Well, I think our point, Your Honor,  
12          is principally an entire lack of evidence and the plaintiffs  
13          -- the plaintiffs, in fact, excluded the VA entirely from  
14          their own analysis when they present a theory of diversion.

15          But putting aside the VA shipments, McKesson is only  
16          the sixth largest distributor of prescription opioids into  
17          Cabell-Huntington.

18          And putting aside the VA, McKesson shipped 5.5 million  
19          pills into Cabell-Huntington from 2006 to 2014.

20          So, I have put up a slide here from Mr. -- Dr. McCann.  
21          He said there were 36 distributors of prescription opioids  
22          in Cabell-Huntington over this period. There were five  
23          companies that shipped more than McKesson. That amounted to  
24          close to 200 million MMEs of pills. And, as he said, that's  
25          not a dominicus amount. So, in other words, there's a lot

1 of others that were distributing in Cabell-Huntington.

2 And so, McKesson's share if you remove the VA amounts  
3 to six percent of the volume of shipments into  
4 Cabell-Huntington putting aside the VA. And if the  
5 plaintiffs' entire theory is high volume it doesn't hold  
6 water as to McKesson.

7 Now, plaintiffs blur this point by pointing to McKesson  
8 shipments outside of Cabell-Huntington. Their directed  
9 verdict briefing names nine pharmacies served by McKesson  
10 that are between 50 and 150 miles outside of Cabell County  
11 and the red dots on this slide reflect it, quite a long way  
12 away, and they just pointed to two pharmacies in  
13 Cabell-Huntington in their briefing that were customers of  
14 McKesson, I should say.

15 And as Dr. McCann testified, there is no evidence that  
16 any patients from Huntington or Cabell ever visited any of  
17 the nine pharmacies outside of Cabell-Huntington that the  
18 plaintiffs had identified and we've quoted that on the  
19 slide. He did not identify any patients who went to any of  
20 those pharmacies from Cabell-Huntington.

21 The plaintiffs also go even further outside Huntington  
22 and Cabell to internet pharmacies that were operating in  
23 Florida, but the evidence of diversion and drug trafficking  
24 related to internet pharmacies is completely stale.  
25 Congress barred internet pharmacies in 2008. It's not been

1 happening for over a dozen years, as Mr. Rannazzisi  
2 acknowledged.

3 And even as to the internet pharmacies operating prior  
4 to 2008, there's no evidence that any distributor in this  
5 case ever shipped to any internet pharmacy whose pills made  
6 their way to Huntington or Cabell. There is just no  
7 evidence on this at all that links these internet pharmacies  
8 to Huntington-Cabell, but perhaps the more important point  
9 of all is it's more than a dozen years old and we're in a  
10 forward-looking case.

11 So, in short, there's no evidence that links McKesson  
12 shipments to these other pharmacies to any harms in  
13 Cabell-Huntington and McKesson's small share in  
14 Cabell-Huntington defeats causation. These small shipments  
15 cannot have been a substantial factor in plaintiffs' claim  
16 that excessive volumes of opioids caused them harm.

17 The claims cannot properly rely on this talisman of 81  
18 million pills as their core theory of liability without  
19 grappling with the fact that McKesson had only a very, very  
20 small share of that volume. They can't have both sides of  
21 this.

22 And McKesson, in fact, had only a few customers in  
23 Cabell-Huntington and none were even mentioned in the  
24 plaintiffs' closing. As Mr. Ashworth, the sales rep who  
25 serves Cabell-Huntington said, currently has three customers

1 in Cabell-Huntington and he had a couple of customers if he  
2 went back to 2010. And the plaintiffs have no evidence of  
3 any wrongdoing in McKesson's sales to these customers or any  
4 misconduct by its customers.

5 Mr. Rafalski said he was not offering any opinions  
6 about whether diversion occurred at a pharmacy level in  
7 Cabell-Huntington.

8 And Mr. Rannazzisi said he could not identify any  
9 orders that he believes DEA should have blocked in  
10 Cabell-Huntington but were not.

11 The only -- and to the contrary -- so there's no  
12 evidence of misconduct and, to the contrary, the West  
13 Virginia Board of Pharmacy concluded that Rite Aid, one of  
14 McKesson's customers in Cabell-Huntington, dispenses  
15 medications only for legitimate medical purpose and is a,  
16 quote, "good pharmacy", in all caps, underlined, and with an  
17 exclamation point, the Board of Pharmacy reviewing Rite Aid,  
18 one of McKesson's customers, consistently finding it was  
19 complying with the law and was a good pharmacy.

20 The only other record evidence of a McKesson customer  
21 in Cabell-Huntington relates to Custom Script, which was the  
22 twenty-sixth largest pharmacy in the community, and served  
23 primarily oncology clinics and Hospice facilities.

24 Now, let's contrast that. Let's contrast the lack of  
25 evidence of any -- of any wrongdoing with the evidence of A+

1 Pharmacy.

2 The evidence reflects that Miami-Luken, a distributor  
3 that's not in this case, supplied A+ Pharmacy, a bad  
4 pharmacy that was shut down in Cabell-Huntington. A+  
5 Pharmacy was never supplied by any of these defendants. A+  
6 dispensed more than a half million prescription opioids and,  
7 in 2014 alone, this represented 97 percent of the pills  
8 seized by the Huntington Police Department.

9 Your Honor, if we wanted to find a case of actual  
10 pharmacy-level diversion, actual wrongdoing, this would be  
11 it. This is what it looks like. This is the kind of  
12 evidence that the Court might have been anticipating when  
13 the case began. Yet, Miami-Luken is not even a defendant in  
14 this case that alleges harm from the distribution of  
15 opioids.

16 So, as we've discussed, the plaintiffs' case is based  
17 on their claim that the volume of prescription opioids was  
18 excessive. That's the core. That's the heart of what  
19 they're claiming.

20 But the key players who contributed to this volume of  
21 prescription opioids are not parties here. Doctors who  
22 prescribed the volume of pills. Drug dealers who illegally  
23 trafficked prescription opioids into the community.  
24 Manufacturers who developed these prescription opioids and  
25 then promoted the prescribing of these pills to doctors.

1 Pharmacies that dispensed prescription opioids in  
2 Cabell-Huntington.

3 Three distributors, not defendants here, that accounted  
4 for a larger volume of prescription opioids in  
5 Cabell-Huntington than McKesson. And Miami-Luken, of  
6 course, which supplied A+ Pharmacy.

7 These are clear examples of missing parties that had a  
8 much more direct role in the volumes at stake here and the  
9 volumes that the plaintiffs relied upon, volumes that  
10 plaintiffs claim their harm.

11 So, to sum up, there is no record evidence to support a  
12 finding that McKesson was a substantial factor in causing  
13 the opioid crisis in Cabell-Huntington, particularly where,  
14 unlike Miami-Luken, there's no evidence of any issues with  
15 any of the pharmacies McKesson served.

16 So, Your Honor, let me turn to a new subject. The  
17 plaintiffs claim the distributors' failure to report  
18 suspicious orders proves causation, but they have no  
19 evidence linking suspicious order reporting to diversion or  
20 to any harms in Cabell-Huntington. The evidence, in fact,  
21 directly contradicts plaintiffs' theory that diversion was  
22 caused by the defendants' failure to report suspicious  
23 orders.

24 First of all, McKesson and the others always reported  
25 all shipments to the ARCOS database. These volumes were

1 known and fully available to the DEA. And they were public,  
2 always public, at the three-digit zip code level.

3 No federal or state regulator ever said that McKesson's  
4 shipments were excessive or inappropriate. No federal or  
5 state regulator ever said that McKesson's shipments were  
6 unreasonable.

7 The evidence also establishes that McKesson always  
8 blocked orders that were likely to be diverted. It was very  
9 clear it was done before 2008 and after 2008. Orders likely  
10 to be diverted were always blocked. And it's important to  
11 emphasize that orders likely to be diverted are different  
12 from suspicious orders.

13 I'm sure the Court has struggled a bit with the  
14 language of this regulation, the classically vague  
15 regulatory formulation defining a suspicious order as an  
16 order of unusual size or frequency or deviating from a  
17 normal pattern.

18 The record establishes that there are many benign,  
19 completely neutral reasons that an order might vary in size  
20 or frequency. Mr. Rafalski said there were all kinds of  
21 circumstances where an order can be of unusual size, pattern  
22 or frequency and not be diverted. He agreed with that  
23 statement.

24 Now, before 2008, based on DEA's guidance and industry  
25 practice, McKesson reported all suspicious orders, but only

1 blocked the orders that it believed were likely to be  
2 diverted.

3 Mr. Rannazzisi testified that no distributor, no  
4 distributor, was blocking all suspicious orders before 2008.  
5 And we see this reflected clearly in the money case, *United*  
6 *States v. \$463,000-and-some* out of the Eastern District of  
7 Michigan where the Court said that it was a standard  
8 practice to file Suspicious Order Reports while continuing  
9 to ship products and further said that practice had been  
10 approved by the DEA. This was based on testimony of DEA  
11 witnesses. And there was also testimony in that case that  
12 DEA changed its policies around 2006 or '7.

13 We see the same point in the *Masters Pharmaceutical*  
14 decision from the D. C. Circuit which similarly reflects  
15 that the requirement not to ship suspicious orders was first  
16 articulated in the *Southwood* decision, which was in 2007.

17 So, we see starting in 2008 McKesson blocked all  
18 suspicious orders, but it reported less. That was based on  
19 specific guidance from DEA that it wanted fewer Suspicious  
20 Order Reports, and it -- but it did want distributors to  
21 block all suspicious orders.

22 Now, in 2008, McKesson reached a settlement agreement  
23 with DEA that involved no admission of wrongdoing and, in  
24 response, the DEA reviewed and passed McKesson's Suspicious  
25 Order Monitoring Program. McKesson told DEA that it would



1 be reporting fewer suspicious orders as DEA had requested.

2 DEA passed and raised no objection to that practice.

3 In 2017, McKesson entered into a second Settlement  
4 Agreement with DEA. This related to suspicious order  
5 reporting before 2013 because McKesson changed its reporting  
6 immediately after this issue first arose in 2013. The only  
7 admission, the only admission in that Settlement Agreement,  
8 related to whether McKesson had sufficiently reported those  
9 suspicious orders.

10 The 2017 settlement had no admission of any failure to  
11 block. There's a very important distinction between  
12 reporting and blocking. There was no admission of any  
13 failure to block suspicious orders and there was no  
14 admission of any diversion or any lack of sufficient due  
15 diligence on customers or orders.

16 So, this second settlement reflected DEA's changing  
17 guidance on the reporting of suspicious orders that it  
18 wanted more. There was a period of time when it wanted  
19 less. It then wanted more. That was based -- that was  
20 reflected in this settlement.

21 But, notably, the evidence also reflects that DEA did  
22 nothing with these Suspicious Order Reports even when they  
23 were received. There was no action taken on any suspicious  
24 orders.

25 Mr. Rafalski acknowledged that he couldn't point to any

1 action that DEA took on any suspicious order that McKesson,  
2 Cardinal or ABDC made for Cabell County or Huntington.

3 Mr. Rannazzisi couldn't even say whether more than one  
4 percent of suspicious orders had triggered an investigation  
5 by DEA.

6 And, in fact, we see a recent Office of Inspector  
7 General Report that's in the record that found an utter  
8 failure by DEA to take any action in response to this  
9 suspicious order reporting. One finding was that the  
10 suspicious order reporting database was seen within DEA as  
11 a, quote, "joke" and that Field Division staff did not even  
12 have access to this suspicious order reporting database  
13 until 2017.

14 Another finding was that when they asked the Field  
15 Division staff to find Suspicious Order Reports, they  
16 couldn't even locate them.

17 So, this evidence reflects that it would not have  
18 mattered if more suspicious orders had been reported. DEA  
19 was doing nothing with them even when they were reported.

20 Perhaps even more important, Your Honor, for purposes  
21 of this forward-looking case, there is no evidence of any  
22 failures to report suspicious orders after 2013. So, here  
23 we are in 2021 in a case that seeks a forward-looking remedy  
24 over 15 years and the evidence establishes, first, that all  
25 orders likely to be diverted have always been blocked. All

1 orders likely to be diverted have always been blocked. And  
2 the evidence establishes that all suspicious orders have  
3 been blocked since at least 2008; so, for more than a dozen  
4 years.

5 There cannot be any harm or any diversion from orders  
6 that were blocked and not shipped. Mr. Rannazzisi  
7 acknowledged this. He agreed if the order is blocked the  
8 medicine can't go downstream. It makes sense. If it's  
9 blocked it can't get out to the public. It can't be  
10 diverted.

11 Mr. Rafalski said the same thing. He agreed, if you  
12 block an order, it would not lead to diversion. He said  
13 blocking the order -- he agreed, blocking the order is what  
14 prevents diversion.

15 Now, Mr. Rafalski did suggest that more orders should  
16 have been flagged and he came up with his own methodology  
17 for flagging more suspicious orders. And there's been quite  
18 a bit of briefing to the Court on this. I'll go through it  
19 quickly.

20 The important point is his testimony cannot be  
21 credited. He used a methodology that was never used at the  
22 DEA to identify suspicious orders and was created solely for  
23 purposes of litigation. He presented six methods for  
24 detecting suspicious orders, but on the witness stand he  
25 disclaimed four of them as not plausible.

1           He had no opinion about how many flagged orders should  
2           have been reported to DEA. He did not evaluate the medical  
3           needs related to any harm from flagged orders.

4           He had a remarkably wide range of error, from  
5           20 percent in one analysis to 97 percent in another,  
6           shocking imprecision in methodology and his analysis was  
7           incompatible with DEA's own estimate of only .1 percent of  
8           orders being suspicious and diverted.

9           So -- and he also applied -- he applied his  
10          no-due-diligence assumption without reviewing any orders and  
11          I want to go back to that point in a little more detail.

12          What happened with Mr. Rafalski's methodology was a  
13          highly artificial flagging of orders. If the threshold was  
14          exceeded in one month, his method assumed that all  
15          subsequent orders were suspicious even if none exceeded the  
16          threshold after that first month.

17          And the Court will recall these two charts, the one on  
18          the left reflecting his assumption that every order after a  
19          first month should have been flagged as suspicious when, in  
20          fact, only one month's order exceeded the threshold, as  
21          reflected in the right-hand side of this slide.

22          Mr. Rafalski based his methodology on an assumption  
23          that no diligence was conducted on suspicious orders. That  
24          was an assumption he did not check and it was contradicted  
25          by the record. The record establishes that McKesson and

1 others systematically conducted diligence on blocked orders.  
2 And Mr. Rafalski said in response to that point he couldn't  
3 find evidence of this diligence a decade later when he did  
4 his analysis.

5 But the evidence established that there was no  
6 requirement to keep diligence records for a decade or more.  
7 Generally speaking, the records retention was two years for  
8 these diligence files, as reflected in the testimony of Mr.  
9 Oriente and others. So, the fact that Mr. Rafalski couldn't  
10 find diligence files a decade later is not proof that the  
11 diligence was not done and, to the contrary, the direct  
12 evidence from those who were involved is that diligence was  
13 done. It was conducted for both customers and orders. And  
14 this evidence directly undermines the core premise and the  
15 core assumption of Mr. Rafalski's flagging methodology.

16 Furthermore, even if Mr. Rafalski is right that more  
17 orders should have been flagged as suspicious, an order,  
18 whether it is suspicious or not, would sit on the shelf  
19 harming no one unless a doctor writes a prescription and the  
20 pills are dispensed.

21 And this is the point that Dr. Gupta made, Dr. Keyes  
22 made. They both agree pills don't leave the pharmacy  
23 without a prescription. I think we've established that  
24 clearly in this record.

25 And this shows why the plaintiffs' theory of harm is

1 not based on suspicious order monitoring or reporting and I  
2 want to underscore that. Their theory of harm is not based  
3 on suspicious order reporting.

4 Their theory of harm depends on prescriptions being  
5 written. The only harm that occurs is when doctors write  
6 prescriptions and the pills are dispensed and out in the  
7 community.

8 The question of whether more orders should have been  
9 reported doesn't bear on the question of whether, in fact,  
10 the pills get out into the community. That is caused by  
11 doctor prescribing. This is made very clear in the  
12 testimony of Mr. Rafalski, who agreed that not reporting  
13 suspicious orders to DEA is not what causes diversion.

14 It also bears emphasis that the State of West Virginia  
15 has repeatedly licensed McKesson to distribute prescription  
16 opioids. That reflects the State's own finding that  
17 McKesson is operating in compliance with federal legal  
18 requirements and is maintaining effective controls against  
19 diversion. That's the basis for the State of West  
20 Virginia's authorizations.

21 And based on these determinations, the State of West  
22 Virginia has approved McKesson 150 times since 2014 alone  
23 and I would submit that ties back, Your Honor, to the public  
24 nuisance point we discussed a bit ago. The State needs  
25 these distributors to operate, to provide medicines that

1 doctors are prescribing.

2 The Court need not resolve every detail of these  
3 suspicious order reporting issues to conclude that they're  
4 irrelevant to plaintiffs' claimed harm. Failures to report  
5 some suspicious orders, even if they happened, could not  
6 have contributed to excessive volume and could not have  
7 caused harm because the record establishes these orders were  
8 blocked and never shipped. Whether they were reported or  
9 not, they were blocked.

10 And I want to highlight again the harm that the  
11 plaintiffs claim in this case is from the volume of pills  
12 dispensed by pharmacies that went into medicine cabinets and  
13 ended up being misused, abused, or given away. That harm  
14 could not have occurred from orders that were blocked and  
15 never shipped. Whether or not more should have been  
16 reported to DEA as suspicious, the point is, they were  
17 blocked. They didn't contribute to the volume that the  
18 plaintiffs claim caused them harm.

19 I'm ready to turn to a new subject, Your Honor. Should  
20 we keep going?

21 THE COURT: Yeah. I think we probably need a  
22 break here, Mr. Hester.

23 MR. HESTER: All right, Your Honor.

24 THE COURT: We will be in recess for ten minutes.

25 (Recess taken)

1 THE COURT: You may proceed, Mr. Hester.

2 MR. HESTER: Thank you for the short break, Your  
3 Honor.

4 Before I move on to my next topic, I did want to go  
5 back to one point. I don't want to oversell the idea of  
6 class actions for products cases. I don't want to -- I  
7 don't want to overstate the prospects for that.

8 I do think, perhaps as this litigation reflects, there  
9 are ways to consolidate litigation through Bellwethers and  
10 other mechanisms probably, in fairness, class actions  
11 involving straight products liability claims have not been  
12 certified so far as we know. So, I checked with my  
13 brethren, who know more about this than I do, but I just  
14 didn't want to oversell to the Court that that was an easy  
15 alternative.

16 I think it's probably complicated, but I think our real  
17 point is it's not a public nuisance and there would be  
18 consolidated frameworks by which that kind of litigation  
19 could be handled, as we're seeing in this case.

20 So, let me turn along to my next subject, which is  
21 illegal drug abuse. I'm going to turn to what we see as a  
22 different gap in the plaintiffs' evidence of causation  
23 related to illegal drug abuse.

24 The evidence shows a 50 percent decline in opioid  
25 prescribing since 2013. The volume of prescription opioids



1 on which plaintiffs stake their case has declined  
2 dramatically.

3 The Pill Mountain that Mr. Farrell highlighted in his  
4 opening has really disappeared or fallen away. And the  
5 recent volumes that we see with prescribing are vastly lower  
6 than Mr. Farrell's 81 million pills between 2006 and 2014.  
7 If we moved it forward, we would see lower volumes.

8 And it's reflected here in the testimony from Dr.  
9 Gupta, who said there's been a quite significant decline,  
10 52 percent decline in prescribing between 2014 and 2019.

11 So, any crisis created by the volume of prescription  
12 opioids ended years ago. That's a highly significant point  
13 in a case involving solely prospective relief. Plaintiffs  
14 have no evidence that today's level, today's level of opioid  
15 prescribing, is excessive and they focused almost entirely  
16 -- when they talk about prescription opioid shipments,  
17 prescription opioid volumes, they're almost always relying  
18 on evidence that's at least a decade old.

19 And there's been a lot of discussion in this case of  
20 evidence as far back as 2007-2008 related to prescription  
21 opioid volumes. That has changed fundamentally.

22 So, the record establishes, in fact, that this is no  
23 longer a prescription opioid crisis. It has shifted. As  
24 Dr. Gilligan said, it has shifted to the abuse and misuse of  
25 heroin and fentanyl and fentanyl analogues. It's a crisis

1 of heroin and fentanyl abuse.

2 Sheriff Zerkle said the same thing. Pills were very  
3 prominent in 2007 to 2010. As of 2017, he said the issue,  
4 predominantly heroin. He said now most of our Drug Unit  
5 stuff is more toward the meth side now.

6 Mr. Lemley stated that the community had, quote, "moved  
7 on from prescription opioids", progressed to heroin and  
8 fentanyl and carfentanil.

9 And Dr. Smith's charts reflected the point and  
10 illustrated the point very clearly that the issue in  
11 Cabell-Huntington today is overdoses from heroin and illicit  
12 fentanyl and we see this enormous spike in fentanyl  
13 overdoses starting around 2014 and moving forward.

14 So, the plaintiffs pivot. With the huge drop in  
15 prescribing they pivot to blame distributors for this  
16 illegal drug crisis, but there are several fundamental flaws  
17 in the illegal drug theory.

18 First of all, this cannot possibly meet the proximate  
19 causation requirements. The plaintiffs' theory is that the  
20 volume of prescription opioids led to later abuse of illegal  
21 drugs, but as the Court is well aware and the record  
22 reflects, illegal drugs are driven by drug cartels and drug  
23 dealers, not the distributors of lawful medicines.

24 Very colorfully stated by Sheriff Zerkle, who talked  
25 about when we arrest someone, there's someone in Detroit

1 saying saddle your horse. You're going to Huntington. The  
2 police documents noting that Huntington has often been  
3 referred to as Little Detroit.

4 Mayor Williams emphasized that Detroit drug dealers are  
5 a significant cause of the opioid problem and he said  
6 Detroit and other cities, yes.

7 And, of course, illegal actors took extensive action to  
8 increase the market for heroin and illicit fentanyl. Dr.  
9 Gupta described they reduced the price of heroin. They  
10 increased the purity of heroin to unseen levels, more pure,  
11 lower price. They increased the supply of heroin.

12 And, as reflected in the report from Dr. Compton of the  
13 National Institute on Drug Abuse, they sold heroin like  
14 pizza, a pizza delivery-like way of marketing heroin to  
15 potential suburban buyers who otherwise might have been  
16 frightened to engage with the illicit drug trade. That's  
17 what's happened in recent years.

18 And, of course, licensed pharmaceutical distributors  
19 had nothing to do with these decisions and with these  
20 actions taken entirely by criminal actors. So, this  
21 criminal activity is a fundamental obstacle to the  
22 plaintiffs' theory based on illegal drug use.

23 There was a nice discussion by Mr. -- Ms. Mainigi this  
24 morning of the sequence. We have prescription opioids  
25 stolen or given away, a crime. Prescription opioids being

1 misused for a non-medical purpose, a crime. A person who  
2 develops OUD as a consequence. A person with OUD who  
3 subsequently acquires illegal drugs, another crime. Drug  
4 traffickers or cartels who supply those illegal drugs,  
5 another crime.

6 Now, the plaintiffs are simply wrong in suggesting that  
7 illegal drugs are just, quote, "the other side of the coin  
8 from prescription opioids", or that prescription opioids,  
9 there was a colorful phrase yesterday in the closings are,  
10 quote, "pharmaceutical grade heroin", kind of a shocking  
11 assertion, I think.

12 To the contrary, heroin abuse is the result of  
13 extensive criminal activity by Mexican drug cartels and  
14 other illegal criminal organizations. By drug dealers. By  
15 those who adulterate heroin with fentanyl. And by those who  
16 buy and abuse those illegal drugs. That is a far cry from a  
17 doctor prescribing an FDA approved medicine for the  
18 treatment of a legitimate medical need.

19 *City of Charleston* again tells us the answer and  
20 demonstrates that proximate causation cannot be established  
21 as to this illegal drug activity. Illegal drug use under  
22 the *City of Charleston* test is unduly remote. And we've put  
23 the language up here on the slide where plaintiffs claims  
24 rely on, quote, "various criminal actions by third parties".  
25 The Court found that these were too many intervening causes,

1 including the criminal actions of third parties.

2 That's the exact same issue presented here in relation  
3 to illegal drug use. It's already been decided by the *City*  
4 *of Charleston* decision.

5 Now, the plaintiffs try to bypass this issue of  
6 proximate causation by arguing it was foreseeable that  
7 prescription drug abuse would lead to later illegal drug  
8 use, but that's not a correct statement of West Virginia  
9 law, as we've previously discussed. Remoteness and  
10 foreseeability are both elements of proximate causation  
11 under West Virginia law, as *City of Charleston* itself  
12 reflects.

13 But even under the plaintiffs' foreseeability theory  
14 there's no evidence that these harms were foreseeable.  
15 There is no evidence that distributors should have foreseen  
16 and expected that illegal drug cartels from Mexico and  
17 elsewhere would flood the market with low price high purity  
18 heroin or would adulterate the heroin supply with illicit  
19 fentanyl.

20 There's no evidence that doctors prescribing medicine  
21 in good faith foresaw illegal drug use.

22 There's no evidence that DEA foresaw illegal drug use  
23 when it was continually increasing the quotas for  
24 prescription opioids.

25 There's no evidence that FDA foresaw illegal drug use

1 when it approved prescription opioids for the treatment of  
2 pain.

3 And there's no evidence that the West Virginia Board of  
4 Medicine foresaw illegal drug use when it encouraged doctors  
5 in West Virginia over and over again to be more attentive to  
6 patients' pain and to use more prescription opioids.

7 The illegal drug crisis cannot have been foreseeable to  
8 distributors when every aspect of the healthcare and  
9 regulatory system in this country encouraged increased  
10 prescribing without ever thinking it would lead to a  
11 heroin-fentanyl crisis.

12 So, in short, proximate causation is a complete answer  
13 to a claim of harms flowing from prescription opioids to  
14 subsequent illegal drug use. It fails on proximate  
15 causation grounds under *City of Charleston*.

16 But there's also a second complete answer to  
17 plaintiffs' illegal drug theory. Plaintiffs, of course,  
18 have asserted a direct causal gateway between prescription  
19 opioids and later illegal drug use. This does not stand up  
20 to the evidence.

21 Plaintiffs rest their gateway theory on the evidence  
22 that many heroin users previously abused prescription  
23 opioids, but the plaintiffs do not have evidence  
24 establishing that prior abuse of prescription opioids causes  
25 -- causes later heroin abuse.

1           Rather, the evidence reflects that what we're measuring  
2           here is a broader substance abuse problem, that heroin users  
3           who previously abused prescription opioids in fact abused  
4           many other drugs.

5           And the most powerful study on that is the one  
6           reflecting that 80 percent of heroin users had previously  
7           abused prescription opioids, something we've talked about  
8           with the Court quite a bit, but that same study also found  
9           that almost 100 percent of those heroin users had previously  
10          abused other illegal drugs, reflecting this point. It's a  
11          substance abuse problem. It's not a simple gateway, pills  
12          to heroin.

13          Dr. Keyes acknowledged that heroin users have broader  
14          substance abuse problems. She noted the most common first  
15          substance use is tobacco and alcohol. Then there's a  
16          progression to other drugs.

17          Dr. Gilligan described the same point, that it's a  
18          broader substance abuse problem that we're seeing.

19          And this was summed up nicely and effectively in the  
20          article from Dr. Compton, again, the Director -- Deputy  
21          Director of the National Institute on Drug Abuse, who said  
22          that "conclusions", quote, "about cause and effect between  
23          prescription opioid abuse and later heroin abuse is  
24          uncertain and that other factors explain this transition  
25          from one to the other, including changes in the heroin

1 supply and the heroin market."

2 So, in short, the supposed gateway, the theory that  
3 prescription opioid abuse causes, causes later heroin abuse,  
4 is not supported by the evidence. And the evidence of a  
5 gateway is surely too thin, too thin to hold distributors  
6 liable for the illegal drug activity of criminal actors in  
7 drug cartels.

8 But I want to emphasize the Court need not resolve this  
9 whole gateway issue to reject these illegal drug claims for  
10 failure to proximate causation. It's a much simpler way to  
11 get to the answer because *City of Charleston* tells us the  
12 answer. They can't establish proximate causation where they  
13 have all of these intervening acts of illegal actors in the  
14 drug chain for illegal drugs. We don't need to resolve the  
15 gateway to reach the conclusion under *City of Charleston*.

16 Let me turn to my last topic, Your Honor, the abatement  
17 remedy. In our Rule 52 motion and argument we already  
18 addressed the core legal and analytical flaws in the  
19 abatement remedy.

20 And just to summarize briefly, almost the entire remedy  
21 is for treatment and for harms related to opioid abuse. The  
22 remedy is not addressing the distributors' conduct but is  
23 instead seeking payment for the treatment of opioid use and  
24 addiction and related harms.

25 And in their closings yesterday, both Mr. Farrell and



1 Ms. Kearse highlighted that the plaintiffs are seeking money  
2 predominantly for treatment of addiction as the core element  
3 of their remedy. Yet, the plaintiffs waived any claim for  
4 damages, stated clearly in this slide on the board, and  
5 treatment costs are clearly damages arising from opioid  
6 addiction and abuse.

7 In addition, and even more fundamentally, abatement,  
8 the purpose of abatement, is to address conduct giving rise  
9 to a nuisance, not the downstream harms caused by the  
10 nuisance. Here the claimed nuisance, as the plaintiffs have  
11 articulated it, is the excessive distribution of the volume  
12 of opioids. Yet, the plaintiffs are not seeking any remedy  
13 that's realistically tied to the level of distributions or  
14 the volume of prescription opioids. They're instead seeking  
15 money for the harms caused by addiction and abuse.

16 Treatment of harms is not a proper abatement remedy.  
17 That is not addressing the conduct said to give rise to the  
18 nuisance.

19 Another flaw. A huge part of the plaintiffs' remedy is  
20 for future addiction for people who develop addiction years  
21 into the future. The Court will recall the question that  
22 was put to Dr. Alexander about a child who is ten years old  
23 as of 2021, has never used opioids, begins using opioids in  
24 -- or begins abusing heroin in 2027 as a teenager and  
25 develops OUD. That person who develops OUD years into the

1 future from heroin abuse would be included within the scope  
2 of the plaintiffs' remedy.

3 Yet, the plaintiffs have no evidence of any future  
4 conduct, future conduct by defendants, that could make them  
5 liable for this kind of future addiction. And, in fact,  
6 plaintiffs' abatement brief acknowledges this point. They  
7 say there will be new cases that are required to be abated,  
8 quote, "whether or not they are the direct result of  
9 defendants' conduct".

10 That's a fairly shocking concept, liability without  
11 causation. It's directly at odds with basic principles of  
12 tort law to suggest that new cases could be subject to  
13 abatement that these defendants have to pay for, whether or  
14 not the result of defendants' conduct.

15 The remedy also includes people who were never exposed  
16 to prescription opioids at all, another central flaw in  
17 causation, the suggestion that somehow a person who has  
18 never, ever been exposed to prescription opioids would be  
19 entitled to be included within the scope of this abatement  
20 remedy. Defendants cannot be held liable for harms to  
21 people who are never exposed to the products they  
22 distribute.

23 Another flaw. The remedy is clearly unreasonable. The  
24 City and the County do not administer or pay for these  
25 services and would receive vast amounts of money for

1 programs in which they play no role. So, today, the City  
2 and the County in total devote \$136,000.00 to opioid-related  
3 projects and -- projects and programs. That's based on the  
4 testimony of Dr. Rufus. And the plaintiffs are claiming  
5 \$2.5 billion dollars when they spend today \$136,000.00 on  
6 opioid-related programs.

7 And as reflected in particular in the fact -- in the  
8 statement by the mayor, he said the City has never funded  
9 opioid treatment and he said I never would expect the city  
10 government to actually start running treatment programs.  
11 Yet, more than \$2 billion dollars, more than \$2 billion  
12 dollars of this remedy, is for treatment programs. So, the  
13 City would be receiving this vast amount of money for things  
14 it does not do.

15 And, in fact, as the Court has heard, almost everyone  
16 in West Virginia has health insurance which already covers  
17 these treatment costs and health insurance is not grant  
18 funding. It's health insurance that already pays for the  
19 treatment costs that make up the vast bulk of the  
20 plaintiffs' abatement plan and there's no record evidence  
21 that this health insurance funding is unstable or uncertain  
22 into the future and there's no evidence in this record that  
23 this funding that already exists is inadequate to provide  
24 ongoing funding for the treatment programs for people in  
25 Cabell-Huntington with addiction.

1 Now, plaintiffs have made the suggestion that it's no  
2 issue that they don't run or pay for these programs today  
3 because they want the Court to establish a, quote, "court  
4 supervised trust fund" to pay for the programs that the City  
5 and County do not fund or administer.

6 There is, first of all, no evidence in this record that  
7 third parties need additional funds to provide the programs  
8 to address the opioid crisis that they're already providing.  
9 There's no evidence in this record. It's silent on that  
10 issue. So, there is no evidence to support creating a fund  
11 for programs that have never shown a need for more funding.

12 For instance, funding is not needed to pay for  
13 treatment programs that Medicare and other insurance already  
14 pay for. And without evidence, there's no basis to  
15 establish this fund. There's no basis to establish a need  
16 for a fund to support programs that are already running  
17 without this funding.

18 But perhaps even more fundamentally, Your Honor, the  
19 idea of this Court-supervised trust fund is unmoored from  
20 tort law principles of causation. It would suggest the  
21 Court can create a fund that disburses money to parties that  
22 have made no showing of any injury caused by the defendants.  
23 There would be no mechanism by which that would happen.  
24 These parties are not here and they would be receiving money  
25 somehow out of this fund.

1           And the plaintiffs have also presented no evidence or  
2           explanation as to how the fund would be administered or  
3           overseen, who would be eligible for payments from the fund,  
4           what the criteria would be for determining payments from the  
5           fund, or what would happen with unused funds.

6           This is social policy. It's not a tort principle.

7           But let's put to one side the flaws of this fund  
8           proposal and the flaws that we already discussed in our Rule  
9           52 motion. Let's look at the record evidence. The record  
10          evidence demonstrated that Dr. Alexander's model is  
11          unreliable and reflects a total failure of methodology.

12          First of all, the Court will recall the testimony of  
13          Dr. O'Connell about the Resiliency Plan. The Resiliency  
14          Plan was developed by the community to assess what sort of  
15          resources they needed as they looked ahead over a 40-year  
16          period, what would they need to become healthy, as Dr.  
17          O'Connell put it, and that Resiliency Plan directly  
18          contradicts Dr. Alexander's estimate, for instance, that the  
19          City and County need over \$2 billion dollars in treatment  
20          money as we look ahead.

21          And recall that Dr. O'Connell said that the premise of  
22          this Resiliency Plan was to assume no budget, no limit, no  
23          constraint on the funding. What would you need? Assume no  
24          limits. And that's -- and that's what the community came up  
25          with.

1           So, let's look at what they did. They came up with a  
2 Resiliency Plan. The first draft had treatment costs of  
3 \$23 million dollars. Unspecified duration.

4           The next version of the plan, treatment costs of  
5 \$50 million dollars over 40 years. Again, assuming no limit  
6 on funding at all, that's the number that the community came  
7 up with when they assessed what they were doing and what  
8 they would need as they looked ahead.

9           That \$50 million dollars continued through the  
10 August 22 draft. Continued into the September 3, 2019  
11 draft, the last version that had numbers in it before those  
12 were stripped out.

13           Let's look at what the abatement plan number has.  
14 Instead of \$50 million dollars over a 40-year window, which  
15 is what the community said it needed, the abatement plan  
16 shockingly comes up with a number for treatment of over \$2  
17 billion dollars over 15 years. It just utterly impeaches  
18 the credibility of this abatement plan.

19           And as reflected in what we see here, we see this huge  
20 divergence between the Resiliency Plan and Dr. Alexander's  
21 model. We can see that the individual cost projections in  
22 his model are completely inflated.

23           For an example, he comes up with a Syringe Services  
24 Program number and his Syringe Services Program number as  
25 calculated by Mr. Barrett was for a number of \$12.6 million

1 dollars over a 15-year window and that would serve roughly  
2 1,000 people.

3 Well, the plaintiffs had an expert, Dr. Feinberg, who  
4 testified that she had actually run a Syringe Services  
5 Program for \$60,000.00 a year serving perhaps 1,400 or 1,500  
6 people. Now, note Dr. Feinberg's number was an annual  
7 number. So, multiply it by 15. Still \$900,000.00 compared  
8 to \$12 million. It's just a shocking divergence from  
9 reality in what we see in the Alexander model.

10 We see another example. The treatment costs that Dr.  
11 Alexander estimated failed to take account of the actual  
12 duration of treatment that we see in the real world.

13 The TEDS data that was discussed during the trial is  
14 the data compiled by the federal government that reflects  
15 the actual duration of treatment and the TEDS data reflects  
16 that the actual duration of outpatient treatment on average  
17 is 71 days.

18 Well, Dr. Alexander assumed 365 days. And he had other  
19 categories of treatment where he similarly assumed very long  
20 outpatient programs that would be much, much longer than  
21 that 71-day number.

22 So, Dr. Rufus did the calculation. If we just made  
23 that one adjustment, 71 days instead of this unrealistic  
24 out-of-touch assumption that Dr. Alexander made, we would  
25 drop the treatment number in the Alexander plan by \$1

1 billion dollars. The fact that one assumption changes the  
2 numbers by a billion dollars shows they are unreliable.

3 Now, the plaintiffs yesterday in their closing  
4 suggested that the defendants somehow had, quote, "agreed"  
5 that the proper treatment number, therefore, must be between  
6 \$600 million and \$1.7 billion, the Rufus number versus the  
7 Alexander number. I think they missed the point entirely.

8 We've already discussed why the plaintiffs are not  
9 entitled to recover anything for treatment. Treatment is  
10 for downstream harms caused by drug abuse. It's not  
11 properly abatement and the plaintiffs have waived any claim  
12 for damages.

13 But the key point is, it just reflects a flaw of  
14 methodology. That's the reason that we're highlighting this  
15 point. When numbers swing a billion dollars from making an  
16 assumption that simply reflects the reality of what's  
17 happening in this country it raises fundamental questions  
18 about the reliability of the model. There's also clearly an  
19 utter failure in the Alexander model to take any account of  
20 the community activity that's already underway.

21 Now, the plaintiffs in their paper that they filed  
22 over this past week said that the Alexander plan, quote,  
23 "takes into account that current programs are insufficient".  
24 That's simply not true and that's not what the evidence is  
25 in this record.



1 Dr. Young said that it was beyond the scope of her  
2 report to look at what is in Cabell County and she said  
3 there are other experts who were doing that, not her. Well,  
4 in fact, no expert for the plaintiffs did that.

5 Dr. Alexander said he didn't do it. He was asked did  
6 you subtract out the level of services that are currently  
7 being provided? No, I did not.

8 Mr. Barrett said he didn't do it either. He didn't  
9 take any account of the programs that are currently being  
10 offered in Cabell and Huntington and he said, no, and that's  
11 not how Dr. Alexander developed his model.

12 The last witness in this case, Your Honor, at trial was  
13 Ms. Colston, Stephanie Colston, who is an expert with  
14 extensive experience in evaluating treatment programs and  
15 abatement programs and she said -- she made the common sense  
16 point, but I think it's powerful, that you've got to know  
17 what you have before you allocate resources. How can we  
18 allocate \$2.5 billion to a problem without knowing what the  
19 community is already doing?

20 Sort of a stunning thought, as she said, if you don't  
21 know whether the current resources are full or whether  
22 they're empty or they have a waiting list, how could you do  
23 -- how could you undertake the exercise? As she said, I  
24 don't see how you can evaluate need in a community without  
25 it.

1           And, in fact, as the Court has heard, there is a  
2           tremendous number of programs that are already operating in  
3           the City and the County. Sheriff Zerkle again colorfully  
4           said what we've turned into is a, quote, "recovery  
5           epicenter".

6           Dr. O'Connell described at some length the City of  
7           Solutions document and all of the programs that are already  
8           underway in the City and the County to address various  
9           opioid-related issues.

10          And Mayor Williams was asked about the City of  
11          Solutions document and the guide that was put in place to  
12          explain Huntington's successes in the fights against opioids  
13          and he said -- he was asked none of those programs is funded  
14          from the budget of the City and he answered and they never  
15          will be and never should be. Fine. But that really  
16          undermines the premise of this entire abatement model.

17          There's another flaw in Dr. Alexander's methodology.  
18          He deviated from his own methodology in a way that renders  
19          his report unreliable.

20          The Court may recall that Dr. Alexander had submitted  
21          the same kind of redress model in four different opioid  
22          cases. He developed what he calls an Apollo model, which is  
23          an extensive model with dozens of variables, many dozens of  
24          inputs of 25 or 40-page write-ups of how this model works  
25          and operates and he also described that he did extensive

1 calibration and testing to make sure that the model was  
2 accurate. He submitted that in Ohio in March, 2019.

3 He submitted a comparable model in the Washington  
4 litigation in January 20, 2021. Again, an Apollo model.  
5 Dozens of variables. Many dozens of inputs. Extensive  
6 testing and calibration.

7 Same thing in Rhode Island in June, 2021. His Apollo  
8 model submitted again; extensive, extensive testing, dozens  
9 of variables.

10 Well, what did he do here? He submitted a model based  
11 on the Jack Homer paper. He didn't use his own model. He  
12 used the Jack Homer paper. He had a one-sentence  
13 description of what he did, a one-sentence description as  
14 compared to this elaborate, extensive analysis of variables  
15 and inputs.

16 He did no calibration or testing because, as he said,  
17 it's not my model. I couldn't test it. Well, it just shows  
18 a shocking deviation from his own methodology. And there  
19 was no explanation provided as to why he deviated from his  
20 own methodology.

21 So, let's look a little bit more at the Homer paper.  
22 Dr. Alexander said it was important to consider funding as  
23 one is evaluating science. The funding has to be considered  
24 as one is interpreting the science.

25 He was unaware, he said, that the paper, the Homer

1 paper, was funded by two of the plaintiff law firms that are  
2 representing the plaintiffs in this case. Levin Papantonio  
3 represents the City of Huntington. Baron & Budd represents  
4 the Cabell County Commission. Those two law firms funded  
5 this Homer paper which bizarrely Dr. Alexander used rather  
6 than his own model.

7 Dr. Alexander also said that he'd never rely on someone  
8 he didn't know when he's evaluating one of these scientific  
9 papers. "I typically do consider the background and  
10 training of authors." So, I asked him, "Do you know who  
11 Jack Homer is?" "No, I do not." Pretty stunning. Pretty  
12 stunning in terms of how grossly he deviated from his own  
13 methodology. And these flaws of methodology undermine his  
14 entire opinion. They make it reliable -- unreliable and  
15 unsound.

16 But let's put aside the unreliability of Dr.  
17 Alexander's model.

18 Whoops. Sorry, Your Honor.

19 (Pause)

20 Let's put aside the unreliability of Dr. Alexander's  
21 model. There's an even more fundamental flaw. Dr.  
22 Alexander asserted that the success of his model was it  
23 would reduce opioid overdoses and overdose deaths by  
24 50 percent over 15 years. That's -- that's his benchmark  
25 for putting in \$2.5 billion in resources into a community of

1 90,000 people. It would reduce overdoses and overdose  
2 deaths by 50 percent over 15 years.

3 But that has already happened in -- in two years -- or  
4 three years between 2017 and 2019 and it did not cost  
5 \$2.5 billion. The County and the City have already achieved  
6 the objective, the benchmark that Dr. Alexander articulated  
7 as his success for his own model. And the evidence reflects  
8 that between 2017 and 2019 there's been a reduction in  
9 opioid overdoses of 52 percent and overdose deaths of 46.7  
10 percent.

11 This is further evidence that defeats any basis for  
12 awarding of funds to achieve an objective that the community  
13 has already achieved without these funds. There's no basis.  
14 When the City and the County are already achieving these  
15 objectives, there's no basis for the award being sought.

16 And, finally, and perhaps even most significantly, the  
17 plaintiffs have made no showing that the City or the County  
18 even need this additional funds to address the opioid crisis  
19 or to achieve their objectives. It seems to have been  
20 assumed, but there is no proof of that.

21 And, as we said, the City and the County are spending  
22 on opioid-related issues \$136,000.00 today. And we see that  
23 the City is running a budget surplus of \$17 million, which  
24 represents 25 percent of its budget. And the County is also  
25 running a surplus, although it's smaller.

1 Mayor Williams testified that he had no plans to  
2 allocate any of that surplus to opioid-related issues.  
3 There is no evidence of any additional funding needs to  
4 address the opioid crisis when the City and the County are  
5 not allocating any of their surplus to address the opioid  
6 crisis.

7 Furthermore, at the state level there are unused funds  
8 for opioids of roughly \$80 million dollars, as Ms. Colston  
9 testified. Again, there is no evidence that the City and  
10 the County have made any effort to seek any of those funds  
11 for any purpose.

12 So, this is a complete absence of proof of any unmet  
13 needs for opioid-related issues that would support an award  
14 of funds to the City or the County, let alone a  
15 court-administered trust fund in the billions of dollars.  
16 There is no evidence that, in fact, the City and the County  
17 need more money in order to address the opioid crisis.  
18 They're doing a good job, but they have not made an  
19 evidentiary showing of more need for more funding.

20 So, in short, the plaintiffs have failed to present the  
21 Court with sufficient evidentiary bases to impose a remedy.  
22 Their obligation, as the plaintiffs, is to provide the Court  
23 sitting in equity with sufficient basis to exercise its  
24 equitable discretion in deciding on a remedy.

25 The failures of their methodology mean that the Court

1 is left without a sufficient evidentiary basis to act.

2 Just as in a damages case, a plaintiff seeking  
3 equitable relief must present evidence to support its claim  
4 for that relief. There's no such evidence here.

5 No evaluation of what's actually being done in the  
6 community. No evaluation of what more is needed. A flawed  
7 methodology based on a paper that was funded by the  
8 plaintiffs' law firms and with obviously flawed assumptions  
9 and estimates.

10 And virtually the entirety of the remedy being sought  
11 is to address the effects of opioid abuse; yet, the  
12 plaintiffs have waived damages in this case and are not  
13 entitled in their abatement case to recover for downstream  
14 harms from an alleged nuisance.

15 And virtually nothing in the proposed remedy is  
16 addressed to the distributors' conduct or to anything  
17 related to what the distributors have allegedly done to  
18 create a nuisance.

19 The plaintiffs cannot properly throw all of this into  
20 the Court's lap without sufficient evidence to guide its  
21 decision making and expect the Court to figure this all out.  
22 They've not done enough to come forward to the Court with a  
23 framework to permit the Court to impose the sort of remedy  
24 being sought.

25 So, there's simply no basis for the requested abatement

1 remedy in the record. It's unsupported by the evidence and  
2 it's demonstrably unreasonable at many different levels. We  
3 can tick off a lot of different levels where it's  
4 unreasonable.

5 But the Court need not reach these questions of remedy  
6 because the plaintiffs have not proven their case on the  
7 merits.

8 And so, to return to where I began, the evidence  
9 establishes clearly two points without contradiction.  
10 Doctor prescribing drove the increased volumes of  
11 prescription opioids and the plaintiffs' theory of harm is  
12 based on medicine cabinet diversion which resulted not only  
13 from prescribing decisions by doctors, but also from  
14 multiple criminal acts that plaintiffs' experts themselves  
15 recognized the distributors could not control and were not  
16 responsible for controlling.

17 Given this overwhelming evidence, the plaintiffs cannot  
18 establish proximate causation. *City of Charleston* and  
19 *Employer Teamsters* point the way. They establish the  
20 goalpost. They establish the framework. They decide the  
21 same issue that is before the Court now. They set the  
22 framework for decision.

23 And those cases were decided on pretrial motions. Here  
24 we have a full evidentiary record that defeats a showing of  
25 proximate causation, first, based on the intervening medical



1 judgments of doctors, a point that's culled out in both *City*  
2 *of Charleston* and *Employer Teamsters* as a very substantial  
3 factor defeating proximate causation. Second, we have the  
4 multiple intervening criminal actions of third parties  
5 giving rise to medicine cabinet diversion. *City of*  
6 *Charleston* speaks directly to that.

7 The evidence also defeats a claim of public nuisance.  
8 It cannot be a public nuisance to distribute a medicine that  
9 doctors are prescribing in good faith for the treatment of  
10 pain. Under the *Pope* standard the medical community has  
11 decided that the public interest, quote, "imperatively  
12 demands these medicines". Patients need them.

13 And under the Restatement formulation it cannot be an  
14 unreasonable interference with a public right to supply  
15 medicines that doctors are prescribing to treat patients.  
16 Distributors could not second-guess those decisions and it  
17 would be a perversion of the public nuisance law to suggest  
18 they should have counteracted and disregarded the medical  
19 judgments being made by doctors.

20 Public nuisance law would swallow the entire body of  
21 tort law if the harms from doctors' good faith prescribing  
22 of a medicine can be a public nuisance.

23 And public nuisance law would also override and swallow  
24 the regulatory judgments made by the FDA, the DEA, and the  
25 West Virginia Board of Medicine that encouraged and

1 facilitated the use of these medicines and that left the  
2 weighing of benefits and risks of these medicines to doctors  
3 and not distributors. Now, surely the plaintiffs got past  
4 pretrial motions on this point, but now we have a record  
5 that demonstrates the reasons that this cannot be a public  
6 nuisance.

7 So, I will conclude there, but I did want to conclude  
8 by expressing our very deep appreciation to the Court for  
9 its careful consideration of the evidence and for the many  
10 courtesies it has shown to all of us in this courtroom  
11 throughout this trial. It has been a pleasure to be before  
12 the Court and we are most grateful for the opportunity to  
13 present our case.

14 THE COURT: Thank you, sir.

15 MR. HESTER: Thank you, Your Honor.

16 THE COURT: Mr. Farrell, do you need some time to  
17 get set up?

18 MR. FARRELL: No, sir.

19 THE COURT: Are you ready to go?

20 MR. FARRELL: If they're finished, I'd like the  
21 opportunity to retort.

22 THE COURT: How much -- long do you think?

23 MR. FARRELL: I think less than 30 minutes, Judge.

24 THE COURT: Okay. Then we'll press on, if you're  
25 ready.

1 MR. FARRELL: Over the past several hours it's  
2 been difficult to sit by and listen to some of my  
3 colleagues. On behalf of the City of Huntington and the  
4 Cabell County Commission, we take great offense at some of  
5 the misrepresentations, we believe, of the record.

6 This is Day 40. This is Day 40, appropriately so, and  
7 I'm not going to go through every single one. This isn't a  
8 high school debate where we're trying to keep a scorecard of  
9 points. But there are a couple of individual points that I  
10 do want to bring this Court's attention to.

11 First, we find it remarkable that throughout the three  
12 closing arguments not a mention was made of the highest  
13 court in the land who has commented upon the duty owed by  
14 the distributors in *Masters Pharmaceutical*. Not a word was  
15 mentioned of the duty to maintain effective control.

16 The next point. Supply driving demand. It's not a  
17 concept to be dismissed easily when we're talking about  
18 opium. We're talking about a controlled substance defined  
19 by 21 U. S. C. 812, Subparagraph (2), Subparagraph (b).

20 We're talking about opium. To pretend that the supply  
21 of opium doesn't create addiction and demand totally ignores  
22 the entire premise of why we've regulated this drug as a  
23 controlled two substance. It is a metastasized cancer in  
24 our body politic and will continue to grow.

25 Opium has been around since the Byzantine era. It has

1       toppled governments because it, by its very nature, is  
2       addictive. You can't get opioid addicts without a supply of  
3       opium.

4               When you look at the *Direct Sales* case, Judge Faber,  
5       when you look at the case and you read the volume was the  
6       premise in *Direct Sales* and the United States Supreme Court  
7       said that the volume of morphine sulfate sold by the  
8       wholesaler to the dispensing physician, and I'm quoting at  
9       319 U. S. at 712. 319 United States Reports at 712. "The  
10      primary effect is to create black markets for dope and  
11      increase illegal demand and consumption." In this instance,  
12      the supply in part was fueling demand.

13             Next point.

14             THE COURT: What were the facts in that case?

15             MR. FARRELL: So, in that case, you had a  
16      wholesale distributor that was selling morphine sulfate  
17      tablets by mail order and, back then, to regulate the  
18      industry you had to have, under the Harrison Narcotic Act,  
19      you had to have a stamp book.

20             So, down in South Carolina, in a town of 2,000 people,  
21      a Dr. Tate was ordering some 6,000 tablets a month. And  
22      there was an indictment of three individuals that had been  
23      using these morphine sulfate tablets.

24             There was an indictment of the dispensing Doctor, Dr.  
25      Tate, and there was an indictment of the wholesaler. And

1 they got convicted. The wholesaler was convicted of  
2 criminal conspiracy and appealed it all the way to the  
3 United States Supreme Court.

4 And when you look at -- and I had it written down.  
5 When you look at -- well, I have it here in my hand, Judge.  
6 Page 713.

7 And, actually, if I may I approach, I've highlighted  
8 it.

9 At Page 713 of the case what you'll see is the defense  
10 -- what you're reading is the standard of care defense that  
11 you just heard for a day and a half. In that case, the  
12 wholesaler said wait a minute. We were providing morphine  
13 sulfate to a doctor that had prescribed it and he had a  
14 stamp book. And the United States Supreme Court says that  
15 doesn't give you immunity, that just because a physician  
16 prescribed it doesn't mean that what you weren't doing was  
17 facilitating criminal diversion.

18 To be clear, Judge, the exact offense that's in the  
19 paragraph I highlighted for you is what we just heard all  
20 day today. And it was not only insufficient defense in the  
21 United States Supreme Court case but, respectfully, Judge,  
22 it was an insufficient defense in closing argument up on the  
23 sixth floor on May 28th of this year. While this case was  
24 pending they convicted a doctor for prescribing medicines.

25 The standard of care defense didn't work in this case

1 in 1943. It didn't work upstairs. And it shouldn't work  
2 here.

3 Now, the next point.

4 THE COURT: According to the scope note in the  
5 case, it says that the seller not only knew the physician  
6 was selling the drug illegally, but it intended to cooperate  
7 with him. So, that makes that case a little bit different  
8 than this one, doesn't it?

9 MR. FARRELL: Well, no, Judge, because when you  
10 read the body of the case what the United States Supreme  
11 Court said is that there was no actual agreement. There was  
12 no overt act of what you just said. The United States  
13 Supreme Court says that when you sell that much it infers  
14 that you are acquiescing.

15 So, when you read the entire length of that opinion  
16 what it suggests is that when you act over such a period of  
17 time with such volume, you are deemed to act not only in  
18 mind, but in hand, to further and facilitate the diversion  
19 of controlled substances.

20 THE COURT: That was in 1943.

21 MR. FARRELL: Yes, sir.

22 THE COURT: We didn't have the regulatory  
23 framework that you have that applies here, correct?

24 MR. FARRELL: That is correct. That's why you'll  
25 recall from Dr. Courtright, Dr. Courtright said is that, in

1 1970, we created one organic body of law and codified the  
2 closed system. This Harrison Narcotic Act was just the  
3 infant of the more complex regulatory system we have today.

4 But the point of the matter is, is that there has been a  
5 recognition in the United States for a significant period of  
6 time that if we don't control narcotics then they will get  
7 out into the black market.

8 THE COURT: That's what the DEA is all about,  
9 isn't it?

10 MR. FARRELL: Yes, sir, it is, and that's why the  
11 DEA has been attempting to implement the system designed by  
12 Congress and the one part of the system the DEA has  
13 consistently been arguing with the defendants about is their  
14 role in the system.

15 So, the facts of this case, we may very well agree on a  
16 lot of the facts. We may very well agree that doctors were  
17 writing too many prescriptions. They should agree that  
18 there are doctors that went to prison.

19 We all agree that if you -- if you make, sell,  
20 distribute prescription opioids you have to be in the closed  
21 system. No one disputes the number 81 million.

22 The real dispute in this case is whether or not the  
23 defendants, the distributors, have a duty to control supply.  
24 Respectfully, Judge, if they have no duty to control supply,  
25 they shouldn't even need a registration. They should just

1 need delivery trucks.

2 They have a duty, they have a duty in supply, then  
3 there is an abrogation of that in Huntington-Cabell County,  
4 West Virginia. And the reason I say that is because the  
5 volume of pills that were sold is clearly unusual. Clearly  
6 deviating from the normal pattern.

7 So, I respect the fact that since 2005 Cardinal Health,  
8 McKesson and AmerisourceBergen have steadfastly denied that  
9 it is their responsibility to control the supply of  
10 prescription opioids. I respect the fact that that's their  
11 position.

12 The DEA has on this record with Mr. Prevoznik testified  
13 that they were in violation of their regulatory obligations.  
14 The DEA told them so. The DEA warned them. Provided  
15 notice. Sanctioned them. Sanctioned Cardinal Health twice,  
16 the second time resulting in an acknowledgment of  
17 wrongdoing. Sanctioned McKesson twice, the second time with  
18 McKesson acknowledging wrongdoing. And that, nonetheless,  
19 today in this courtroom the three companies are continuing  
20 to say the same thing, it's not their duty.

21 What that tells me, Your Honor, is that if this happens  
22 again, they would do it again. If, in fact, it's true that  
23 the only thing that they need is an order form from a  
24 registered pharmacist and that's all they need, that's the  
25 defense that was -- the exact defense rejected in the *Direct*



1       Sales case.

2               What's the purpose of a closed system if we're not  
3 going to try to regulate and keep the pills for legitimate  
4 medical needs?

5               I want to take a brief minute and make a comment about  
6 James Rafalski because he's a good man and I think his  
7 credibility has been disparaged by the defendants today.

8               What Mr. Rafalski's testimony is about is that assuming  
9 -- just assume for the fact that there is a duty for the  
10 defendants to monitor unusual patterns. Let's just assume  
11 they had that duty. The question then is what is unusual  
12 and, once you detect an unusual pattern, what do you do  
13 about it?

14              So, one of the reasons that I gave you the big, big  
15 wieldy charts is so that you could see in some absurd  
16 conclusion with hydrocodone pills that, at some point in  
17 time, there were, in month one, 180,000 hydrocodone pills  
18 sold to a pharmacy in Logan County.

19              Now, let's just take that for a minute. If, in one  
20 month, you sell 180,000 hydrocodone pills to a pharmacy in  
21 Logan, what is your immediate response? My immediate  
22 response is that's -- that's too many pills.

23              When I look at it and I see that the national average  
24 is 3,000, the state average is 3,700, if you're selling  
25 180,000 to 1 pill (verbatim), there's a mistake. Something

1 should happen.

2 What Mr. Rafalski's testimony is and what his common  
3 sense is that if you get an order for 180,000 pills,  
4 somebody should probably stop and check and make sure that  
5 this isn't a mistake because it seems like it's a clerical  
6 mistake.

7 You shouldn't ship 180,000 pills to a pharmacy in  
8 Logan. And if you have a system that has some type of  
9 safety valve, 180,000 should be enough to trigger the safety  
10 valve. And if the safety valve gets triggered what we  
11 should not see is the next month another 170,000 pills.

12 THE COURT: Well, what does a pharmacy in Logan  
13 have to do -- a situation in Logan County have to do with  
14 Cabell County and the City of Huntington?

15 MR. FARRELL: Okay. I -- I'm using the pharmacy  
16 in Logan as an absurd spectrum to demonstrate why Mr.  
17 Rafalski is being criticized here. Mr. Rafalski is trying  
18 to demonstrate that once a system --

19 THE COURT: Well, you can't put an expert on the  
20 stand in a case that's this important and expect him not to  
21 be attacked, Mr. Farrell.

22 MR. FARRELL: I -- I understand, Judge, but you  
23 also, I would hope, allow me for the opportunity to defend  
24 him.

25 THE COURT: Well, you're doing a pretty good job.

1 Go ahead.

2 MR. FARRELL: So, by applying these same metrics  
3 to Cabell County what we're attempting to demonstrate is  
4 that something unusual happened.

5 Now, the final thing before I move into what ultimately  
6 I want to discuss is about the abatement plan and I'm going  
7 to -- I'm going to quote my co-counsel, Ms. Ann Kearse.  
8 This is the line that she gave me that I think perfectly  
9 captures what my heart is on this.

10 We shouldn't let the perfect be the enemy of the good.  
11 And I think that sums up what this abatement plan is. You  
12 can poke holes in it. You can criticize it.

13 But what you haven't seen, Judge, is an alternative  
14 proposed by the defendants. If you find them liable, they  
15 have not put in an alternative plan. All they have  
16 attempted to do is convince you to award less money.

17 So, what I thought about before listening to the  
18 comments, what I wanted to say to you, Judge Faber, before  
19 we ended --

20 Will you bring up the slide?

21 So, I like to fish and I understand that you may have,  
22 too.

23 THE COURT: So do I, Mr. Farrell.

24 MR. FARRELL: And so, this is not the Cranberry  
25 River, but it very well could be if those were rhododendron

1 bushes that were hanging over.

2 And I lived with my wife Jackie up in Morgantown for a  
3 period of time. And what we used to do is we used to pop  
4 over into Maryland and then straight down to a little town  
5 called Barnum, West Virginia, which is on the south branch  
6 of the south fork of the Potomac right at the tail waters of  
7 the Jennings Randolph dam.

8 THE COURT: I know it well, Mr. Farrell.

9 MR. FARRELL: So, if we go to the next slide,  
10 please.

11 What we would do, and this is how big of a nerd I was  
12 about it, I would look at the output of the Jennings  
13 Randolph dam and watch for subtle changes in the output.  
14 And then I would watch to see with the rain and the output  
15 how it had subtle changes in the gauge of the height and  
16 what it did to water temperature because we were monitoring  
17 these outputs because little subtle differences can make a  
18 big thing.

19 That, to me, is what I hear when I hear the defendants  
20 talk about their monitoring and the subtle changes in the  
21 practice of medicine. But this isn't what happened in  
22 Huntington-Cabell County, West Virginia. What happened was  
23 something different.

24 That's what happened here. The Upper Gauley. I've  
25 been to the Upper Gauley. I've stood on those rocks. I've

1 watched that water come out.

2 Judge, this isn't a subtle change in the behavior of  
3 practices that happened as the sole cause. This was a  
4 blowout. If we were to take the measurements at Barnum,  
5 those fancy Corps of Engineers measurements, and we were to  
6 measure what happened in Huntington-Cabell County, it  
7 wouldn't look like those subtle changes in water level. It  
8 would look like this. That's what -- that's what the water  
9 levels would look like.

10 So, go to the next one, please.

11 So, here -- here's kind of the metaphor that I want to  
12 draw about what the defendants are saying. The defendants  
13 are the dam and they're standing up on top of the bridge  
14 there. They're standing up above the water and they're  
15 looking down. And the volume of water that comes out is  
16 under their control.

17 Now, this isn't an issue of the safety valve failed.  
18 This volume of water here at the -- at the bottom, at the  
19 bottom of Summersville Lake here, somebody turned it on.  
20 It's not an accident. They had to turn it open.

21 That's what's the difference here, Judge. This isn't  
22 that the distributors were just passengers on this event.  
23 They -- they weren't, you know, standing by watching it.

24 What they are, they're active participants charged by  
25 the United States Code and the Code of Federal Regulations

1 to be responsible for the control valve. They're the ones  
2 that are supposed to see not just the subtle changes in the  
3 water levels, they're supposed to prevent the blowouts.

4 And that's what we had in this case, was we had a  
5 blowout. We had 81 million pills that came flooding into  
6 our community and it wasn't by accident, Judge. Somebody  
7 delivered those pills here and it was the distributors.

8 Their argument that they were all prescriptions written  
9 by doctors is insufficient to immunize them or a safe harbor  
10 for their regulatory responsibilities. If they don't want  
11 to be responsible for controlling the volume of prescription  
12 opioids, they should get out of the business. The reason  
13 they don't want to get out of the business is they don't  
14 want to lose the bigger accounts.

15 This is a component of their job, to watch for, to  
16 monitor -- design, monitor, and to block orders that are  
17 suspicious. And if the number of pills that came into  
18 Huntington-Cabell County, West Virginia isn't suspicious, I  
19 don't know what is.

20 The causation argument is best stated by Ms. Colston,  
21 the very last witness in this case, and what she  
22 acknowledged is we don't have to show that the dam operator  
23 is the cause of the -- of the flood. They only have to be a  
24 substantial cause.

25 And if the defendants owe a duty, and if they breach

1 that duty, they are certainly a proximate cause. And to  
2 stand by and to say that it has nothing to do with them when  
3 the community downstream from this got wiped out defies the  
4 very nature of the closed system.

5 So, in closing --

6 You can take that down.

7 As a historian, you're going to know that there's a  
8 very old story, one I'm fond of, and that old story has a  
9 man who is walking down a road and he comes upon ten lepers.  
10 And I've heard this story told, re-told, many times, but I  
11 wanted to share with you a version that I overheard which  
12 holds some weight and significance in my mind.

13 You see, we call the story -- we originally call the  
14 story *The Ten Lepers*, but it was originally written in  
15 Greek, and then translated to Latin, and then I heard it in  
16 English. And the Greek word is lepra (phonetic) and it's  
17 not that this man walking on the street came upon ten  
18 lepers. The Greek word is that he came upon ten men with  
19 leprosy.

20 You see, even in that old book, it recognized that  
21 these were ten human souls that suffered from leprosy and  
22 that leprosy didn't define them as lepers, it's what they  
23 were suffering from. And this distinction makes a lot of  
24 difference in the mission that we have because we have human  
25 souls that are suffering from addiction.

1           So, you see, I have not lost faith that we can cleanse  
2           our community, Judge, but faith alone may be insufficient.  
3           What we need to do is a lot of work. And after four years,  
4           my work is now done, and I -- I truly believe in my heart  
5           that I have done all that I can and now we entrust this work  
6           to your capable hands. Magic or tragic, there will be a  
7           reckoning.

8           Thank you for your time and patience.

9           THE COURT: Thank you, Mr. Farrell.

10          I assume you want to submit revised proposed findings  
11          and conclusions; is that right?

12          MR. MAJESTRO: Yes, Your Honor.

13          MS. MAINIGI: Yes, Your Honor.

14          MR. HESTER: Yes, Your Honor. That's the plan.

15          THE COURT: How much time do you need to do that?

16          Get my instructions here.

17          (Pause)

18          THE COURT: My advisor has offered the choice  
19          between two and three weeks from today.

20          MR. MAJESTRO: We would prefer three. The other  
21          -- the other question I have for my colleagues on the other  
22          side of the aisle is whether they intend to file replies on  
23          the Rule 50(c) motions?

24          MR. HESTER: Yes, we do.

25          MR. MAJESTRO: We would like to see those before



1 we file our final -- final proposed order.

2 MR. HESTER: Your Honor, we needed a little time  
3 to work both on the Rule 52 replies, as well as -- as well  
4 as the findings. Could we have two weeks from today to  
5 submit the replies and three weeks from today to submit the  
6 findings?

7 THE COURT: Is that all right with you, Mr.  
8 Majestro?

9 MR. MAJESTRO: That works for us, yes. Yes, sir.

10 THE COURT: All right. That's what we'll do.

11 All right. Is there anything else before we adjourn?

12 I want to thank the lawyers for the character and  
13 competence and the quality of your work. It's made what  
14 otherwise would have been a very unpleasant several weeks  
15 much less so.

16 (Laughter)

17 THE COURT: And I want to thank all of you for  
18 your hard work and the way you've treated the Court. I  
19 appreciate it very much.

20 And I'll wait to see your submissions.

21 SIMULTANEOUS SPEAKERS: Thank you, Your Honor.

22 (Trial adjourned at 2:55 p.m.)

23

24 CERTIFICATION:

25 I, Ayme A. Cochran, Official Court

1 Reporter, and I, Lisa A. Cook, Official Court Reporter,  
2 certify that the foregoing is a correct transcript from  
3 the record of proceedings in the matter of The City of  
4 Huntington, et al., Plaintiffs vs. AmerisourceBergen  
5 Drug Corporation, et al., Defendants, Civil Action No.  
6 3:17-cv-01362 and Civil Action No. 3:17-cv-01665, as  
7 reported on July 28, 2021.

8  
9 S\Ayme A. Cochran

s\Lisa A. Cook

10 Reporter

Reporter

11 July 28, 2021  
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<b>\$</b>	<b>142.19</b> <sup>[1]</sup> - 30:15 <b>14th</b> <sup>[1]</sup> - 43:13 <b>15</b> <sup>[5]</sup> - 106:24, 126:17, 127:7, 132:24, 133:2 <b>15-year</b> <sup>[1]</sup> - 127:1 <b>150</b> <sup>[2]</sup> - 98:10, 110:22 <b>15910</b> <sup>[1]</sup> - 3:15 <b>1600</b> <sup>[1]</sup> - 3:15 <b>170,000</b> <sup>[1]</sup> - 146:11 <b>1717</b> <sup>[2]</sup> - 6:6, 6:13 <b>180,000</b> <sup>[6]</sup> - 145:17, 145:20, 145:25, 146:3, 146:7, 146:9 <b>19087</b> <sup>[1]</sup> - 6:15 <b>19103</b> <sup>[2]</sup> - 6:6, 6:13 <b>1920</b> <sup>[1]</sup> - 85:16 <b>1943</b> <sup>[2]</sup> - 142:1, 142:20 <b>1970</b> <sup>[1]</sup> - 143:1 <b>1980s</b> <sup>[1]</sup> - 40:9 <b>1990s</b> <sup>[3]</sup> - 15:10, 15:23, 25:17 <b>1996</b> <sup>[1]</sup> - 16:24 <b>1997</b> <sup>[4]</sup> - 19:1, 19:2, 33:10, 33:18 <b>1998</b> <sup>[6]</sup> - 19:9, 19:23, 20:15, 21:6, 29:14, 29:17	<b>2007-2008</b> <sup>[1]</sup> - 113:20 <b>2008</b> <sup>[17]</sup> - 36:4, 40:5, 40:7, 41:19, 48:8, 48:14, 52:9, 71:22, 98:25, 99:4, 103:9, 103:24, 104:4, 104:17, 104:22, 107:3 <b>2009</b> <sup>[4]</sup> - 21:3, 21:5, 45:17, 45:19 <b>2010</b> <sup>[6]</sup> - 21:3, 21:12, 25:8, 33:10, 100:2, 114:3 <b>2010s</b> <sup>[1]</sup> - 15:10 <b>2011</b> <sup>[14]</sup> - 65:24 <b>2012</b> <sup>[14]</sup> - 8:5, 22:25, 23:2, 40:5, 40:6, 46:11, 46:18, 47:3, 47:6, 47:7, 48:4, 48:8, 48:25, 53:22 <b>2013</b> <sup>[5]</sup> - 57:21, 105:5, 105:6, 106:22, 112:25 <b>2014</b> <sup>[7]</sup> - 75:17, 97:19, 101:7, 110:22, 113:6, 113:10, 114:13 <b>2015</b> <sup>[2]</sup> - 53:24, 66:2 <b>2016</b> <sup>[7]</sup> - 23:20, 34:11, 53:25, 60:18, 62:4, 66:5, 66:9 <b>2017</b> <sup>[7]</sup> - 66:11, 105:3, 105:10, 106:13, 114:3, 133:4, 133:8 <b>2018</b> <sup>[3]</sup> - 24:4, 66:13, 66:16 <b>2019</b> <sup>[5]</sup> - 113:10, 126:10, 131:2, 133:4, 133:8 <b>202</b> <sup>[2]</sup> - 2:4, 2:13 <b>2020</b> <sup>[1]</sup> - 68:2 <b>2021</b> <sup>[8]</sup> - 1:19, 7:4, 106:23, 121:23, 131:4, 131:7, 154:7, 154:11 <b>2027</b> <sup>[1]</sup> - 121:24 <b>21</b> <sup>[2]</sup> - 18:14, 139:19 <b>22</b> <sup>[1]</sup> - 126:10 <b>2216</b> <sup>[1]</sup> - 3:7 <b>25</b> <sup>[3]</sup> - 5:5, 130:24, 133:24 <b>25301</b> <sup>[3]</sup> - 2:8, 3:13, 4:24 <b>25322</b> <sup>[1]</sup> - 6:9 <b>25338-3843</b> <sup>[1]</sup> - 5:15 <b>25701</b> <sup>[1]</sup> - 3:10 <b>26</b> <sup>[1]</sup> - 7:20 <b>28</b> <sup>[7]</sup> - 1:19, 4:3, 4:12, 4:14, 7:4, 154:7, 154:11 <b>28th</b> <sup>[1]</sup> - 141:23 <b>29,000</b> <sup>[1]</sup> - 49:7 <b>29464</b> <sup>[3]</sup> - 4:4, 4:12, 4:15 <b>2:55</b> <sup>[1]</sup> - 153:22	<b>600</b> <sup>[1]</sup> - 2:10 <b>6th</b> <sup>[1]</sup> - 3:5
<b>!</b>		<b>7</b>	
<b>'7</b> <sup>[1]</sup> - 104:12 <b>'80s</b> <sup>[1]</sup> - 16:22 <b>'90s</b> <sup>[3]</sup> - 16:22, 25:7, 37:15 <b>'97</b> <sup>[1]</sup> - 20:1 <b>'98</b> <sup>[1]</sup> - 20:1		<b>7</b> <sup>[1]</sup> - 37:8 <b>70130</b> <sup>[1]</sup> - 3:8 <b>707</b> <sup>[1]</sup> - 4:24 <b>71</b> <sup>[2]</sup> - 127:17, 127:23 <b>71-day</b> <sup>[1]</sup> - 127:21 <b>712</b> <sup>[2]</sup> - 140:9 <b>713</b> <sup>[2]</sup> - 141:6, 141:9 <b>716</b> <sup>[1]</sup> - 3:12 <b>725</b> <sup>[2]</sup> - 4:19, 4:21 <b>76</b> <sup>[1]</sup> - 96:4	
<b>0</b>		<b>8</b>	
<b>0</b> <sup>[1]</sup> - 49:25 <b>00907</b> <sup>[2]</sup> - 2:5, 2:14		<b>8,000</b> <sup>[2]</sup> - 92:8, 92:22 <b>80</b> <sup>[3]</sup> - 63:7, 63:8, 119:6 <b>801</b> <sup>[1]</sup> - 3:10 <b>81</b> <sup>[7]</sup> - 73:6, 96:1, 96:3, 99:17, 113:6, 143:21, 150:5 <b>812</b> <sup>[1]</sup> - 139:19 <b>850</b> <sup>[1]</sup> - 5:12	
<b>1</b>		<b>9</b>	
<b>1</b> <sup>[3]</sup> - 108:7, 127:25, 145:25 <b>1,000</b> <sup>[1]</sup> - 127:2 <b>1,400</b> <sup>[1]</sup> - 127:5 <b>1,500</b> <sup>[1]</sup> - 127:5 <b>1.7</b> <sup>[1]</sup> - 128:6 <b>10</b> <sup>[8]</sup> - 7:24, 8:10, 25:14, 28:9, 38:21, 65:17, 68:2, 69:23 <b>100</b> <sup>[2]</sup> - 49:25, 119:9 <b>1001</b> <sup>[2]</sup> - 4:6, 4:9 <b>1022</b> <sup>[1]</sup> - 3:5 <b>10:00</b> <sup>[1]</sup> - 38:22 <b>10:14</b> <sup>[1]</sup> - 38:22 <b>11:00</b> <sup>[1]</sup> - 69:23 <b>11:10</b> <sup>[1]</sup> - 70:10 <b>12</b> <sup>[1]</sup> - 54:5 <b>12(b)(6)</b> <sup>[1]</sup> - 57:10 <b>12.6</b> <sup>[2]</sup> - 34:14, 126:25 <b>126</b> <sup>[1]</sup> - 3:5 <b>12:30</b> <sup>[2]</sup> - 70:7, 70:8 <b>13</b> <sup>[1]</sup> - 8:9 <b>1300</b> <sup>[1]</sup> - 6:15 <b>1311</b> <sup>[2]</sup> - 2:4, 2:14 <b>14.9</b> <sup>[1]</sup> - 37:6 <b>141.2</b> <sup>[2]</sup> - 30:14, 75:17 <b>142</b> <sup>[1]</sup> - 75:19	<b>2</b> <b>2</b> <sup>[5]</sup> - 123:11, 125:19, 126:16, 139:19 <b>2,000</b> <sup>[1]</sup> - 140:20 <b>2.5</b> <sup>[4]</sup> - 123:5, 129:18, 132:25, 133:5 <b>20</b> <sup>[5]</sup> - 37:2, 37:3, 37:7, 108:5, 131:4 <b>20-year</b> <sup>[1]</sup> - 88:11 <b>20.8</b> <sup>[1]</sup> - 34:12 <b>200</b> <sup>[1]</sup> - 97:24 <b>2000</b> <sup>[2]</sup> - 17:16, 43:7 <b>20001</b> <sup>[1]</sup> - 5:12 <b>20004</b> <sup>[2]</sup> - 4:7, 4:10 <b>20005</b> <sup>[3]</sup> - 4:19, 4:21, 5:5 <b>2001</b> <sup>[4]</sup> - 17:24, 18:14, 20:3, 21:14 <b>2002</b> <sup>[1]</sup> - 62:13 <b>2005</b> <sup>[4]</sup> - 20:9, 20:17, 20:20, 144:7 <b>2006</b> <sup>[5]</sup> - 31:16, 75:17, 97:19, 104:12, 113:6 <b>2006-2014</b> <sup>[1]</sup> - 30:13 <b>2007</b> <sup>[9]</sup> - 42:14, 42:21, 43:3, 43:7, 43:24, 44:1, 44:14, 104:16, 114:3	<b>9/7/07</b> <sup>[1]</sup> - 43:12 <b>90</b> <sup>[4]</sup> - 9:24, 50:24, 50:25, 73:10 <b>90,000</b> <sup>[1]</sup> - 133:1 <b>901</b> <sup>[1]</sup> - 4:23 <b>91436</b> <sup>[1]</sup> - 3:16 <b>97</b> <sup>[2]</sup> - 101:7, 108:5 <b>99</b> <sup>[5]</sup> - 9:13, 10:1, 28:22, 31:13, 76:11 <b>99.5</b> <sup>[1]</sup> - 31:10 <b>9:00</b> <sup>[1]</sup> - 7:4 <b>9th</b> <sup>[1]</sup> - 4:6	
		<b>A</b>	
		<b>a.m</b> <sup>[4]</sup> - 7:5, 38:22, 70:10 <b>abated</b> <sup>[1]</sup> - 122:7 <b>abatement</b> <sup>[26]</sup> - 11:18, 11:19, 67:21, 67:22, 72:6, 78:10, 120:16, 120:19, 121:7, 121:8, 121:16, 122:6, 122:13, 122:19, 123:20, 126:13, 126:15, 126:18, 128:11, 129:15, 130:16, 135:13, 135:25, 147:6,	
		<b>3</b> <b>3</b> <sup>[1]</sup> - 126:10 <b>3,000</b> <sup>[1]</sup> - 145:24 <b>3,700</b> <sup>[1]</sup> - 145:24 <b>3.6</b> <sup>[1]</sup> - 63:21 <b>30</b> <sup>[4]</sup> - 78:18, 79:22, 81:16, 138:23 <b>3100</b> <sup>[2]</sup> - 6:5, 6:12 <b>316</b> <sup>[1]</sup> - 2:11 <b>319</b> <sup>[2]</sup> - 140:9 <b>32</b> <sup>[1]</sup> - 7:18 <b>32502</b> <sup>[1]</sup> - 2:11 <b>34</b> <sup>[2]</sup> - 51:23, 51:24 <b>35</b> <sup>[1]</sup> - 55:23 <b>36</b> <sup>[1]</sup> - 97:21 <b>365</b> <sup>[1]</sup> - 127:18 <b>3843</b> <sup>[1]</sup> - 5:14 <b>3:17-cv-01362</b> <sup>[2]</sup> - 1:5, 154:6 <b>3:17-cv-01665</b> <sup>[2]</sup> - 1:11, 154:6	
		<b>4</b> <b>40</b> <sup>[4]</sup> - 1:16, 126:5, 139:6 <b>40-page</b> <sup>[1]</sup> - 130:24 <b>40-year</b> <sup>[2]</sup> - 125:15, 126:14 <b>401</b> <sup>[2]</sup> - 4:6, 4:9 <b>405</b> <sup>[1]</sup> - 2:7 <b>46.7</b> <sup>[1]</sup> - 133:9 <b>463,000-and-some</b> <sup>[1]</sup> - 104:6	
		<b>5</b> <b>5</b> <sup>[3]</sup> - 37:2, 37:6 <b>5.5</b> <sup>[1]</sup> - 97:18 <b>50</b> <sup>[4]</sup> - 98:10, 112:24, 132:24, 133:2 <b>50(c)</b> <sup>[1]</sup> - 152:23 <b>52</b> <sup>[7]</sup> - 91:12, 92:6, 113:10, 120:17, 125:9, 133:9, 153:3 <b>553</b> <sup>[1]</sup> - 6:8 <b>56</b> <sup>[1]</sup> - 3:4 <b>56th</b> <sup>[1]</sup> - 3:5	
		<b>6</b> <b>6,000</b> <sup>[1]</sup> - 140:21	

<p>147:11  <b>ABC</b> [1] - 43:18  <b>ABDC</b> [5] - 7:20,  30:25, 41:15, 42:19,  106:2  <b>ABDC's</b> [2] - 41:17,  43:4  <b>ability</b> [1] - 71:13  <b>able</b> [1] - 21:10  <b>abrogation</b> [1] - 144:3  <b>absence</b> [4] - 56:11,  67:18, 84:3, 134:12  <b>absolutely</b> [3] - 29:1,  30:18, 54:21  <b>absurd</b> [2] - 145:15,  146:16  <b>abuse</b> [38] - 26:19,  35:12, 58:17, 61:16,  62:17, 63:22, 63:23,  64:7, 64:9, 64:15,  68:22, 72:1, 78:24,  112:21, 112:23,  113:24, 114:1,  114:20, 116:12,  116:16, 117:7,  118:24, 118:25,  119:2, 119:11,  119:14, 119:18,  119:23, 120:3,  120:21, 121:6,  121:15, 122:1,  128:10, 135:11  <b>Abuse</b> [3] - 78:4,  115:13, 119:21  <b>abused</b> [7] - 79:1,  111:13, 118:22,  119:3, 119:7, 119:10  <b>abusing</b> [2] - 9:19,  121:24  <b>accepted</b> [1] - 32:9  <b>access</b> [3] - 95:5,  95:7, 106:12  <b>accident</b> [2] - 149:20,  150:6  <b>according</b> [1] - 142:4  <b>account</b> [4] - 127:11,  128:19, 128:23,  129:9  <b>accounted</b> [2] - 11:9,  102:3  <b>accounts</b> [1] - 150:14  <b>accreditation</b> [2] -  18:1, 18:4  <b>accrediting</b> [1] - 83:4  <b>accredits</b> [2] - 17:23,  89:5  <b>accurate</b> [1] - 131:2  <b>achieve</b> [2] - 133:12,  133:19  <b>achieved</b> [2] - 133:5,</p>	<p>133:13  <b>achieving</b> [1] - 133:14  <b>ACKERMAN</b> [1] - 4:5  <b>acknowledged</b> [8] -  8:4, 28:7, 90:25,  99:2, 105:25, 107:7,  119:13, 150:22  <b>acknowledges</b> [1] -  122:6  <b>acknowledging</b> [1] -  144:18  <b>acknowledgment</b> [1] -  144:16  <b>acquiescing</b> [1] -  142:14  <b>acquires</b> [1] - 116:3  <b>Act</b> [8] - 19:11, 19:23,  21:6, 23:4, 24:6,  42:2, 140:18, 143:2  <b>act</b> [9] - 19:11, 23:5,  23:14, 56:19, 135:1,  142:12, 142:16,  142:17  <b>acted</b> [1] - 54:22  <b>acting</b> [6] - 22:17,  22:20, 32:2, 85:19,  85:24, 86:5  <b>action</b> [15] - 12:17,  19:15, 22:9, 24:5,  48:14, 48:24, 48:25,  49:4, 92:22, 92:25,  93:3, 105:23, 106:1,  106:8, 115:7  <b>Action</b> [4] - 1:4, 1:10,  154:5, 154:6  <b>actions</b> [10] - 19:25,  20:1, 74:12, 82:14,  112:6, 112:10,  115:20, 116:24,  117:1, 137:4  <b>active</b> [1] - 149:24  <b>activity</b> [7] - 91:7,  95:20, 115:21,  116:13, 116:21,  120:6, 128:20  <b>actors</b> [11] - 58:7,  58:8, 71:8, 83:13,  83:14, 83:16, 85:2,  115:7, 115:20,  120:6, 120:13  <b>acts</b> [11] - 71:7, 72:23,  77:19, 82:10, 82:18,  82:21, 82:22, 85:5,  86:1, 120:13, 136:14  <b>actual</b> [14] - 8:25,  11:20, 23:22, 64:3,  69:2, 69:4, 69:6,  69:7, 101:9, 101:10,  127:11, 127:15,  127:16, 142:11</p>	<p><b>added</b> [1] - 46:14  <b>addiction</b> [18] - 7:23,  26:20, 64:11, 64:15,  64:17, 64:20, 64:21,  78:24, 120:24,  121:2, 121:6,  121:15, 121:20,  122:5, 123:25,  139:21, 151:25  <b>addictive</b> [2] - 64:12,  140:2  <b>addicts</b> [1] - 140:2  <b>addition</b> [3] - 44:5,  59:17, 121:7  <b>additional</b> [4] - 35:2,  124:7, 133:18, 134:3  <b>address</b> [11] - 18:5,  57:12, 86:15, 121:8,  124:8, 130:8,  133:18, 134:4,  134:5, 134:17,  135:11  <b>addressed</b> [5] - 39:3,  72:19, 92:19,  120:18, 135:16  <b>addressing</b> [2] -  120:22, 121:17  <b>adequate</b> [2] - 68:1,  90:7  <b>adhere</b> [1] - 89:1  <b>adjourn</b> [1] - 153:11  <b>adjourned</b> [1] - 153:22  <b>adjustment</b> [1] -  127:23  <b>administer</b> [2] -  122:24, 124:5  <b>administered</b> [2] -  125:2, 134:15  <b>admission</b> [6] -  104:23, 105:7,  105:10, 105:12,  105:14  <b>admissions</b> [1] - 59:9  <b>admitted</b> [6] - 10:6,  48:20, 49:18, 51:15,  62:12, 71:5  <b>adopt</b> [1] - 17:9  <b>adopted</b> [2] - 21:12,  67:12  <b>adopting</b> [1] - 17:20  <b>adoption</b> [1] - 16:25  <b>adulterate</b> [2] -  116:15, 117:18  <b>adverse</b> [1] - 91:13  <b>advice</b> [1] - 24:3  <b>advisor</b> [1] - 152:18  <b>affect</b> [1] - 64:14  <b>affects</b> [1] - 39:1  <b>afternoon</b> [2] - 70:12,  70:13</p>	<p><b>AG</b> [2] - 20:20, 21:1  <b>AG's</b> [1] - 44:8  <b>agency</b> [1] - 88:5  <b>aggregate</b> [1] - 93:21  <b>aggressively</b> [1] -  25:18  <b>ago</b> [2] - 110:24,  113:12  <b>agree</b> [5] - 109:22,  143:15, 143:16,  143:17, 143:19  <b>agreed</b> [22] - 24:17,  25:7, 27:12, 31:13,  31:23, 32:5, 35:9,  59:14, 61:9, 64:1,  64:2, 64:19, 64:22,  74:5, 80:8, 90:7,  103:22, 107:7,  107:11, 107:13,  110:12, 128:4  <b>agreement</b> [2] -  104:22, 142:11  <b>Agreement</b> [2] -  105:4, 105:7  <b>Agreements</b> [1] - 48:8  <b>agreements</b> [4] -  48:10, 48:11, 48:13,  49:9  <b>agrees</b> [1] - 12:2  <b>ahead</b> [7] - 19:2,  39:21, 41:20,  125:15, 125:20,  126:8, 147:1  <b>Aid</b> [2] - 100:13,  100:17  <b>aisle</b> [1] - 152:22  <b>al</b> [4] - 1:7, 1:13,  154:4, 154:5  <b>alarming</b> [1] - 29:4  <b>alcohol</b> [1] - 119:15  <b>Alexander</b> [17] -  121:22, 127:9,  127:11, 127:18,  127:24, 127:25,  128:7, 128:19,  128:22, 129:5,  129:11, 130:20,  131:22, 132:5,  132:7, 132:22, 133:6  <b>Alexander's</b> [6] -  125:10, 125:18,  126:20, 130:17,  132:17, 132:20  <b>allege</b> [2] - 33:19, 96:7  <b>alleged</b> [10] - 55:1,  55:7, 55:8, 57:5,  57:6, 72:17, 80:23,  85:3, 86:1, 135:14  <b>allegedly</b> [1] - 135:17  <b>alleges</b> [1] - 101:14</p>	<p><b>allocate</b> [3] - 129:17,  129:18, 134:2  <b>allocating</b> [1] - 134:5  <b>allow</b> [1] - 146:23  <b>allowed</b> [1] - 38:10  <b>allude</b> [1] - 52:2  <b>alluded</b> [1] - 94:2  <b>almost</b> [7] - 63:24,  97:1, 113:15,  113:17, 119:9,  120:20, 123:15  <b>alone</b> [9] - 13:4, 13:11,  22:5, 57:14, 73:8,  101:7, 110:22,  134:14, 152:2  <b>alongside</b> [1] - 91:17  <b>altered</b> [1] - 47:15  <b>alternative</b> [3] -  112:15, 147:13,  147:15  <b>alternatives</b> [1] -  35:25  <b>AMA</b> [1] - 18:15  <b>amalgamation</b> [2] -  92:10, 94:6  <b>amazing</b> [1] - 30:19  <b>amend</b> [1] - 86:23  <b>amended</b> [2] - 21:5,  21:7  <b>America</b> [2] - 36:6,  36:8  <b>American</b> [2] - 17:7,  18:15  <b>AMERISOURCEBER</b>  <b>GEN</b> [2] - 1:7, 1:13  <b>AmerisourceBergen</b>  [4] - 6:2, 42:17,  144:8, 154:4  <b>amount</b> [8] - 13:24,  34:3, 56:9, 74:25,  75:1, 75:3, 97:25,  123:13  <b>amounted</b> [1] - 97:23  <b>amounts</b> [2] - 98:2,  122:25  <b>analogues</b> [1] -  113:25  <b>analysis</b> [11] - 51:8,  57:15, 57:16, 96:9,  96:21, 96:25, 97:14,  108:5, 108:6, 109:4,  131:14  <b>Analytical</b> [1] - 47:18  <b>analytical</b> [2] - 45:7,  120:18  <b>analytically</b> [3] - 45:7,  46:13, 53:1  <b>analyze</b> [2] - 46:14,  52:17  <b>analyzed</b> [1] - 65:6</p>
---	---	--	--	--

<p><b>ANDREW</b> <sup>[1]</sup> - 5:10  <b>Ann</b> <sup>[1]</sup> - 147:7  <b>ANNE</b> <sup>[1]</sup> - 4:2  <b>ANNIE</b> <sup>[1]</sup> - 4:11  <b>announced</b> <sup>[1]</sup> - 43:3  <b>annual</b> <sup>[1]</sup> - 127:6  <b>answer</b> <sup>[9]</sup> - 55:14,  55:15, 86:8, 86:15,  116:19, 118:12,  118:16, 120:11,  120:12  <b>answered</b> <sup>[2]</sup> - 58:1,  130:14  <b>ANTHONY</b> <sup>[1]</sup> - 2:6  <b>anti</b> <sup>[8]</sup> - 20:23, 44:3,  45:2, 46:18, 47:19,  52:12, 52:13, 53:17  <b>anti-diversion</b> <sup>[8]</sup> -  20:23, 44:3, 45:2,  46:18, 47:19, 52:12,  52:13, 53:17  <b>anticipating</b> <sup>[1]</sup> -  101:12  <b>Apollo</b> <sup>[3]</sup> - 130:22,  131:4, 131:7  <b>apparent</b> <sup>[2]</sup> - 56:22,  56:23  <b>appeal</b> <sup>[1]</sup> - 86:25  <b>appealed</b> <sup>[1]</sup> - 141:2  <b>APPEARANCES</b> <sup>[6]</sup> -  2:1, 3:1, 5:1, 5:6,  6:1, 6:10  <b>applied</b> <sup>[5]</sup> - 50:23,  57:7, 94:8, 108:9  <b>applies</b> <sup>[4]</sup> - 58:21,  68:11, 92:14, 142:23  <b>apply</b> <sup>[8]</sup> - 68:7, 84:20,  85:13, 85:14, 86:6,  91:10, 94:5  <b>applying</b> <sup>[4]</sup> - 84:22,  84:23, 94:17, 147:2  <b>apportionment</b> <sup>[1]</sup> -  85:14  <b>appreciate</b> <sup>[1]</sup> -  153:19  <b>appreciation</b> <sup>[1]</sup> -  138:8  <b>approach</b> <sup>[1]</sup> - 141:7  <b>appropriate</b> <sup>[2]</sup> - 80:1,  97:2  <b>appropriately</b> <sup>[4]</sup> -  28:23, 32:13, 76:18,  139:6  <b>approval</b> <sup>[1]</sup> - 44:20  <b>approve</b> <sup>[1]</sup> - 91:21  <b>approved</b> <sup>[16]</sup> - 12:12,  12:16, 27:9, 28:8,  28:9, 41:16, 63:1,  66:23, 87:8, 87:16,  87:18, 89:11,  104:10, 110:22,  116:17, 118:1  <b>arbitrarily</b> <sup>[2]</sup> - 9:18,  9:23  <b>Arch</b> <sup>[2]</sup> - 6:6, 6:13  <b>ARCOS</b> <sup>[2]</sup> - 75:19,  102:25  <b>area</b> <sup>[1]</sup> - 36:13  <b>areas</b> <sup>[1]</sup> - 35:12  <b>argued</b> <sup>[2]</sup> - 13:5  <b>arguing</b> <sup>[2]</sup> - 117:6,  143:13  <b>argument</b> <sup>[7]</sup> - 55:14,  67:12, 69:24,  120:17, 141:22,  150:8, 150:20  <b>arguments</b> <sup>[3]</sup> - 91:12,  92:6, 139:12  <b>arising</b> <sup>[1]</sup> - 121:5  <b>arose</b> <sup>[1]</sup> - 105:6  <b>array</b> <sup>[2]</sup> - 67:14,  81:19  <b>arrest</b> <sup>[1]</sup> - 114:25  <b>arthritis</b> <sup>[1]</sup> - 34:22  <b>article</b> <sup>[2]</sup> - 35:10,  119:20  <b>articulated</b> <sup>[3]</sup> -  104:16, 121:11,  133:6  <b>artificial</b> <sup>[1]</sup> - 108:13  <b>asbestos</b> <sup>[2]</sup> - 93:9,  94:4  <b>ASHLEY</b> <sup>[1]</sup> - 5:3  <b>Ashworth</b> <sup>[1]</sup> - 99:24  <b>aside</b> <sup>[5]</sup> - 97:15,  97:18, 98:4, 132:16,  132:20  <b>aspect</b> <sup>[1]</sup> - 118:8  <b>asserted</b> <sup>[2]</sup> - 118:18,  132:22  <b>assertion</b> <sup>[1]</sup> - 116:11  <b>assess</b> <sup>[2]</sup> - 18:5,  125:14  <b>assessed</b> <sup>[2]</sup> - 84:15,  126:7  <b>assessment</b> <sup>[1]</sup> -  87:19  <b>assume</b> <sup>[5]</sup> - 125:22,  125:23, 145:9,  145:10, 152:10  <b>assumed</b> <sup>[4]</sup> - 108:14,  127:18, 127:19,  133:20  <b>assuming</b> <sup>[3]</sup> - 86:7,  126:5, 145:8  <b>assumption</b> <sup>[8]</sup> -  108:10, 108:18,  108:22, 108:24,  109:15, 127:24,  128:1, 128:16</p>	<p><b>assumptions</b> <sup>[1]</sup> -  135:8  <b>astounding</b> <sup>[2]</sup> - 51:6,  53:3  <b>AT</b> <sup>[1]</sup> - 1:2  <b>attacked</b> <sup>[1]</sup> - 146:21  <b>attempted</b> <sup>[1]</sup> - 147:16  <b>attempting</b> <sup>[3]</sup> - 74:15,  143:11, 147:3  <b>attended</b> <sup>[1]</sup> - 43:10  <b>attention</b> <sup>[5]</sup> - 11:24,  69:18, 88:10, 89:9,  139:10  <b>attentive</b> <sup>[2]</sup> - 88:16,  118:5  <b>attenuated</b> <sup>[2]</sup> - 63:2,  67:8  <b>Attorneys</b> <sup>[1]</sup> - 20:21  <b>August</b> <sup>[1]</sup> - 126:10  <b>authority</b> <sup>[1]</sup> - 84:25  <b>authorizations</b> <sup>[1]</sup> -  110:20  <b>authorized</b> <sup>[1]</sup> - 89:6  <b>authors</b> <sup>[1]</sup> - 132:10  <b>automatic</b> <sup>[1]</sup> - 44:20  <b>automatically</b> <sup>[1]</sup> -  44:25  <b>Autopsy</b> <sup>[1]</sup> - 66:5  <b>available</b> <sup>[14]</sup> - 15:15,  16:14, 23:11, 23:12,  29:17, 46:21, 46:22,  55:21, 64:9, 68:20,  78:7, 90:9, 103:1  <b>average</b> <sup>[8]</sup> - 34:12,  34:14, 37:18, 38:1,  75:16, 127:16,  145:23, 145:24  <b>Avin</b> <sup>[1]</sup> - 3:7  <b>avoids</b> <sup>[1]</sup> - 85:10  <b>award</b> <sup>[4]</sup> - 67:25,  133:15, 134:13,  147:16  <b>awarding</b> <sup>[1]</sup> - 133:12  <b>aware</b> <sup>[4]</sup> - 14:9,  30:24, 46:3, 114:21  <b>Ayme</b> <sup>[2]</sup> - 6:17,  153:25</p>	<p><b>Baron</b> <sup>[2]</sup> - 3:14, 132:3  <b>barred</b> <sup>[1]</sup> - 98:25  <b>Barrett</b> <sup>[2]</sup> - 126:25,  129:8  <b>bars</b> <sup>[1]</sup> - 16:7  <b>bartered</b> <sup>[1]</sup> - 77:25  <b>based</b> <sup>[29]</sup> - 15:15,  25:10, 28:2, 28:4,  31:24, 40:17, 40:24,  69:11, 70:23, 71:1,  74:22, 75:18, 77:16,  87:19, 101:16,  103:24, 104:10,  104:18, 105:19,  108:22, 110:1,  110:2, 110:21,  115:22, 123:3,  131:10, 135:7,  136:12, 136:25  <b>bases</b> <sup>[1]</sup> - 134:21  <b>basic</b> <sup>[4]</sup> - 50:12,  56:20, 58:12, 122:11  <b>basics</b> <sup>[1]</sup> - 40:1  <b>basis</b> <sup>[16]</sup> - 11:13,  27:3, 33:15, 38:5,  49:15, 67:17, 69:14,  110:19, 124:14,  124:15, 133:11,  133:13, 133:15,  134:23, 135:1,  135:25  <b>Baylen</b> <sup>[1]</sup> - 2:11  <b>bear</b> <sup>[1]</sup> - 110:9  <b>bears</b> <sup>[4]</sup> - 84:1,  84:19, 90:10, 110:14  <b>became</b> <sup>[5]</sup> - 13:3,  35:11, 52:9, 74:3,  78:7  <b>become</b> <sup>[3]</sup> - 82:1,  94:10, 125:16  <b>BEFORE</b> <sup>[1]</sup> - 1:17  <b>began</b> <sup>[3]</sup> - 17:9,  101:13, 136:8  <b>begets</b> <sup>[1]</sup> - 63:24  <b>beginning</b> <sup>[1]</sup> - 15:7  <b>begins</b> <sup>[3]</sup> - 22:25,  121:23, 121:24  <b>behalf</b> <sup>[2]</sup> - 92:22,  139:3  <b>behavior</b> <sup>[8]</sup> - 25:23,  75:2, 75:3, 75:23,  78:6, 80:21, 83:18,  149:2  <b>behind</b> <sup>[1]</sup> - 62:17  <b>belabor</b> <sup>[1]</sup> - 31:5  <b>believes</b> <sup>[1]</sup> - 100:9  <b>Bellwethers</b> <sup>[1]</sup> -  112:9  <b>below</b> <sup>[1]</sup> - 8:12  <b>BENCH</b> <sup>[1]</sup> - 1:16</p>	<p><b>benchmark</b> <sup>[2]</sup> -  132:24, 133:6  <b>benefit</b> <sup>[1]</sup> - 84:3  <b>benefits</b> <sup>[10]</sup> - 25:11,  27:4, 87:10, 87:15,  91:12, 91:17, 91:19,  95:2, 95:3, 138:2  <b>benign</b> <sup>[1]</sup> - 103:18  <b>best</b> <sup>[1]</sup> - 150:20  <b>better</b> <sup>[3]</sup> - 39:6,  92:19, 94:20  <b>between</b> <sup>[20]</sup> - 11:4,  48:9, 65:2, 68:15,  72:2, 72:16, 72:19,  81:5, 85:2, 98:10,  105:11, 113:6,  113:10, 118:18,  119:22, 126:20,  128:5, 133:4, 133:8,  152:19  <b>beyond</b> <sup>[1]</sup> - 129:1  <b>big</b> <sup>[5]</sup> - 60:19, 145:14,  148:11, 148:18  <b>bigger</b> <sup>[1]</sup> - 150:14  <b>biggest</b> <sup>[1]</sup> - 42:25  <b>billion</b> <sup>[12]</sup> - 123:5,  123:11, 125:19,  126:17, 128:1,  128:2, 128:6,  128:15, 129:18,  132:25, 133:5  <b>billions</b> <sup>[1]</sup> - 134:15  <b>binder</b> <sup>[2]</sup> - 17:13,  17:14  <b>bit</b> <sup>[10]</sup> - 19:1, 40:3,  51:14, 88:9, 103:13,  107:18, 110:24,  119:8, 131:21, 142:7  <b>bizarrely</b> <sup>[1]</sup> - 132:5  <b>black</b> <sup>[6]</sup> - 53:5, 53:10,  53:15, 87:12,  140:10, 143:7  <b>blame</b> <sup>[2]</sup> - 72:25,  114:15  <b>blamed</b> <sup>[2]</sup> - 59:17,  65:25  <b>block</b> <sup>[5]</sup> - 104:21,  105:11, 105:13,  107:12, 150:16  <b>blocked</b> <sup>[19]</sup> - 71:21,  71:22, 71:23, 100:9,  103:8, 103:10,  104:1, 104:17,  106:25, 107:1,  107:3, 107:6, 107:7,  107:9, 109:1, 111:8,  111:9, 111:14,  111:17  <b>blocking</b> <sup>[4]</sup> - 104:4,  105:12, 107:13</p>
---	---	--	--

## B

**b** <sup>[1]</sup> - 139:19  
**backed** <sup>[1]</sup> - 14:8  
**background** <sup>[2]</sup> -  
21:16, 132:9  
**bad** <sup>[1]</sup> - 101:3  
**balance** <sup>[1]</sup> - 26:21  
**bar** <sup>[1]</sup> - 73:2  
**Barbara** <sup>[1]</sup> - 45:18  
**Barnum** <sup>[2]</sup> - 148:5,  
149:4

<p><b>blocks</b> [1] - 73:16</p> <p><b>blood</b> [1] - 34:24</p> <p><b>blowout</b> [2] - 149:4, 150:5</p> <p><b>blowouts</b> [1] - 150:3</p> <p><b>blue</b> [2] - 16:3, 16:7</p> <p><b>blur</b> [1] - 98:7</p> <p><b>blurred</b> [1] - 85:7</p> <p><b>Blyd</b> [3] - 4:3, 4:12, 4:14</p> <p><b>Board</b> [21] - 12:16, 19:2, 20:3, 20:9, 20:17, 21:1, 21:12, 21:23, 22:10, 24:20, 44:7, 45:5, 88:15, 88:18, 88:24, 88:25, 89:4, 100:13, 100:17, 118:3, 137:25</p> <p><b>board</b> [1] - 121:4</p> <p><b>body</b> [6] - 17:23, 92:13, 137:20, 139:24, 142:10, 143:1</p> <p><b>Bonasso</b> [1] - 5:14</p> <p><b>Boockholdt</b> [2] - 45:19, 46:7</p> <p><b>book</b> [11] - 21:20, 21:22, 21:24, 22:3, 22:6, 22:8, 22:9, 140:19, 141:14, 151:20</p> <p><b>bottle</b> [1] - 97:8</p> <p><b>bottom</b> [7] - 25:22, 32:25, 46:25, 50:12, 55:17, 149:18, 149:19</p> <p><b>Boulevard</b> [1] - 3:15</p> <p><b>bounds</b> [1] - 32:8</p> <p><b>box</b> [1] - 87:12</p> <p><b>Box</b> [2] - 5:14, 6:8</p> <p><b>brain</b> [1] - 64:13</p> <p><b>branch</b> [1] - 148:5</p> <p><b>breach</b> [1] - 150:25</p> <p><b>break</b> [6] - 38:12, 38:23, 38:24, 70:4, 111:22, 112:2</p> <p><b>brethren</b> [1] - 112:13</p> <p><b>bridge</b> [1] - 149:13</p> <p><b>Bridgeside</b> [3] - 4:3, 4:12, 4:14</p> <p><b>brief</b> [5] - 55:13, 68:5, 78:10, 122:6, 145:5</p> <p><b>briefed</b> [1] - 49:11</p> <p><b>briefing</b> [5] - 55:2, 67:23, 98:9, 98:13, 107:18</p> <p><b>briefly</b> [4] - 13:17, 50:14, 70:17, 120:20</p> <p><b>briefs</b> [1] - 84:6</p>	<p><b>bring</b> [5] - 11:24, 54:14, 60:11, 139:10, 147:20</p> <p><b>bringing</b> [1] - 92:8</p> <p><b>broad</b> [1] - 94:12</p> <p><b>broader</b> [3] - 119:2, 119:13, 119:18</p> <p><b>broadly</b> [3] - 17:10, 61:24</p> <p><b>brought</b> [3] - 46:16, 92:7, 92:21</p> <p><b>Budd</b> [2] - 3:14, 132:3</p> <p><b>budget</b> [5] - 65:25, 125:22, 130:14, 133:23, 133:24</p> <p><b>build</b> [1] - 73:15</p> <p><b>building</b> [1] - 73:16</p> <p><b>bulk</b> [4] - 60:9, 67:6, 123:19</p> <p><b>Burling</b> [1] - 5:11</p> <p><b>bushes</b> [1] - 148:1</p> <p><b>business</b> [3] - 55:24, 150:12, 150:13</p> <p><b>buy</b> [1] - 116:16</p> <p><b>buyers</b> [1] - 115:15</p> <p><b>bypass</b> [1] - 117:5</p> <p><b>Byzantine</b> [1] - 139:25</p>	<p>99:23, 99:25, 100:1, 100:7, 100:10, 100:14, 100:21, 101:4, 102:2, 102:5, 102:13, 102:20, 106:2, 114:11, 123:25, 129:2, 129:10, 132:4, 139:4, 144:3, 146:14, 147:3, 148:22, 149:6, 150:18</p> <p><b>cabell</b> [1] - 2:2</p> <p><b>Cabell-Huntington</b> [39] - 70:22, 71:16, 71:18, 71:25, 73:5, 73:9, 73:20, 95:16, 95:19, 95:21, 95:23, 95:25, 96:3, 96:5, 97:17, 97:19, 97:22, 98:1, 98:4, 98:8, 98:13, 98:17, 98:20, 99:13, 99:14, 99:23, 99:25, 100:1, 100:7, 100:10, 100:14, 100:21, 101:4, 102:2, 102:5, 102:13, 102:20, 114:11, 123:25</p> <p><b>Cabell/Huntington</b> [5] - 13:24, 29:6, 30:5, 33:12, 48:20</p> <p><b>cabinet</b> [13] - 60:25, 61:9, 66:25, 71:2, 78:23, 79:6, 80:12, 80:14, 80:22, 82:16, 85:5, 136:12, 137:5</p> <p><b>cabinets</b> [1] - 111:12</p> <p><b>calculated</b> [6] - 8:17, 13:23, 30:12, 30:15, 37:4, 126:25</p> <p><b>calculation</b> [6] - 13:19, 13:20, 13:21, 30:9, 37:4, 127:22</p> <p><b>calculations</b> [2] - 13:19, 75:15</p> <p><b>calibration</b> [3] - 131:1, 131:6, 131:16</p> <p><b>CALLAS</b> [1] - 6:7</p> <p><b>Cameron</b> [5] - 46:17, 46:19, 46:20, 48:1, 52:25</p> <p><b>CAMPBELL</b> [1] - 6:14</p> <p><b>Cancer</b> [1] - 18:15</p> <p><b>cancer</b> [5] - 19:5, 32:2, 35:1, 60:13, 139:23</p> <p><b>cannot</b> [40] - 10:1, 27:8, 39:16, 39:17, 55:1, 57:1, 69:13,</p>	<p>70:19, 71:4, 71:10, 71:23, 72:2, 72:7, 77:1, 77:6, 80:23, 87:4, 87:5, 88:2, 88:4, 89:19, 89:24, 90:2, 90:21, 90:24, 91:3, 92:5, 99:15, 99:17, 107:5, 107:20, 114:18, 116:20, 118:7, 122:20, 135:19, 136:17, 137:8, 137:13, 138:5</p> <p><b>capable</b> [1] - 152:6</p> <p><b>capita</b> [4] - 33:15, 33:19, 34:7, 34:9</p> <p><b>Capitol</b> [1] - 2:7</p> <p><b>caps</b> [1] - 100:16</p> <p><b>captures</b> [1] - 147:9</p> <p><b>Cardinal</b> [64] - 4:16, 5:2, 7:19, 7:24, 8:1, 8:5, 8:7, 8:8, 8:10, 11:4, 11:16, 12:6, 28:15, 28:17, 28:18, 29:4, 30:25, 36:19, 37:9, 40:2, 40:7, 40:10, 40:15, 41:17, 43:4, 43:15, 43:22, 44:1, 44:5, 44:12, 44:15, 44:20, 45:10, 45:15, 46:14, 46:16, 47:3, 47:17, 47:19, 47:23, 49:24, 51:12, 51:19, 51:23, 52:10, 52:13, 53:12, 54:2, 54:22, 55:8, 55:10, 55:19, 56:6, 58:14, 58:23, 59:2, 61:7, 61:17, 62:24, 67:5, 69:11, 106:2, 144:7, 144:15</p> <p><b>Cardinal's</b> [4] - 37:5, 38:6, 41:6, 48:7</p> <p><b>cardiovascular</b> [1] - 34:23</p> <p><b>care</b> [38] - 9:10, 15:11, 15:22, 16:10, 16:11, 16:17, 16:19, 18:13, 20:2, 22:18, 22:21, 22:24, 24:10, 24:12, 24:22, 25:3, 26:5, 26:10, 26:13, 27:18, 28:5, 29:2, 29:7, 36:12, 37:12, 59:5, 59:8, 59:19, 69:12, 70:24, 74:12, 76:24, 77:12, 90:9, 91:9, 141:10, 141:25</p> <p><b>careful</b> [1] - 138:9</p> <p><b>carefully</b> [2] - 10:19,</p>	<p>93:4</p> <p><b>Carey</b> [1] - 4:23</p> <p><b>carfentanil</b> [1] - 114:8</p> <p><b>Carolina</b> [1] - 140:20</p> <p><b>carried</b> [1] - 26:17</p> <p><b>cartel</b> [1] - 67:3</p> <p><b>cartels</b> [5] - 114:22, 116:4, 116:13, 117:16, 120:7</p> <p><b>case</b> [91] - 7:9, 12:23, 13:3, 14:3, 24:14, 33:19, 34:2, 46:21, 48:16, 54:11, 56:22, 57:9, 57:10, 57:11, 57:12, 57:20, 57:21, 57:23, 58:5, 63:3, 67:10, 67:12, 67:14, 67:19, 68:2, 68:3, 68:17, 69:15, 70:25, 72:8, 72:11, 72:12, 73:3, 73:15, 76:22, 78:14, 82:5, 83:2, 84:7, 84:14, 85:16, 85:17, 85:18, 89:20, 92:7, 93:18, 94:24, 95:18, 99:5, 99:10, 101:3, 101:9, 101:13, 101:14, 101:16, 104:5, 104:11, 106:21, 106:23, 111:11, 112:19, 113:1, 113:13, 113:19, 129:12, 132:2, 135:2, 135:12, 135:13, 136:6, 138:13, 140:4, 140:5, 140:14, 140:15, 141:9, 141:11, 141:21, 141:23, 141:25, 142:5, 142:7, 142:10, 143:15, 143:22, 145:1, 146:20, 150:4, 150:21</p> <p><b>cases</b> [24] - 67:17, 68:23, 81:1, 81:6, 81:13, 82:12, 82:23, 84:22, 84:25, 86:14, 86:18, 92:10, 93:9, 93:10, 93:13, 93:19, 94:1, 94:3, 94:15, 112:6, 122:7, 122:12, 130:22, 136:23</p> <p><b>cases"</b> [1] - 92:8</p> <p><b>cast</b> [1] - 68:18</p> <p><b>categories</b> [2] - 52:21, 127:19</p>
<b>C</b>				
<p><b>CA</b> [1] - 3:16</p> <p><b>CABELL</b> [1] - 1:10</p> <p><b>Cabell</b> [108] - 3:2, 7:11, 7:16, 8:18, 9:1, 11:5, 11:20, 12:15, 12:19, 15:4, 29:8, 29:21, 29:25, 30:13, 31:3, 31:6, 32:6, 32:8, 32:11, 32:14, 32:16, 32:17, 32:20, 33:2, 33:6, 33:14, 33:21, 33:24, 36:2, 36:3, 36:18, 36:20, 37:5, 37:9, 37:18, 37:24, 37:25, 38:6, 48:12, 48:23, 51:8, 51:24, 55:11, 55:18, 55:24, 56:7, 58:15, 58:16, 61:14, 62:8, 62:16, 70:22, 71:16, 71:18, 71:25, 73:5, 73:9, 73:20, 75:16, 76:17, 95:16, 95:19, 95:21, 95:23, 95:25, 96:3, 96:5, 97:17, 97:19, 97:22, 98:1, 98:4, 98:8, 98:10, 98:13, 98:16, 98:17, 98:20, 98:22, 99:6, 99:8, 99:13, 99:14,</p>				



<p><b>causal</b> <sup>[12]</sup> - 11:3, 11:9, 60:1, 65:6, 66:20, 72:16, 77:15, 77:16, 77:17, 81:8, 83:8, 118:18</p> <p><b>causation</b> <sup>[58]</sup> - 11:2, 11:17, 54:24, 55:3, 55:4, 55:6, 55:13, 56:13, 57:1, 58:12, 62:19, 65:14, 70:20, 71:9, 72:2, 72:11, 72:15, 72:21, 80:24, 81:3, 81:11, 82:4, 82:12, 82:22, 83:10, 83:15, 83:16, 83:25, 84:4, 84:7, 84:10, 84:12, 84:16, 85:4, 85:8, 85:9, 86:9, 86:11, 86:16, 99:14, 102:18, 112:22, 114:19, 116:20, 117:6, 117:10, 118:12, 118:15, 120:10, 120:12, 122:11, 122:17, 124:20, 136:18, 136:25, 137:3, 150:20</p> <p><b>caused</b> <sup>[32]</sup> - 7:16, 8:15, 9:9, 18:12, 54:25, 58:5, 58:14, 58:15, 58:17, 58:24, 59:11, 59:15, 59:24, 61:1, 61:15, 62:24, 65:16, 77:18, 80:23, 86:1, 92:18, 95:25, 99:16, 102:22, 110:10, 111:7, 111:18, 121:9, 121:15, 124:22, 128:10</p> <p><b>causes</b> <sup>[9]</sup> - 62:20, 82:13, 93:24, 110:13, 116:25, 118:24, 118:25, 120:3</p> <p><b>causing</b> <sup>[6]</sup> - 11:7, 33:25, 34:16, 34:19, 35:5, 102:12</p> <p><b>CDC</b> <sup>[4]</sup> - 23:20, 24:2, 36:4, 66:9</p> <p><b>ceased</b> <sup>[1]</sup> - 45:3</p> <p><b>Center</b> <sup>[2]</sup> - 3:12, 5:11</p> <p><b>center</b> <sup>[6]</sup> - 12:14, 12:15, 41:2, 41:3, 48:22, 49:3</p> <p><b>centers</b> <sup>[5]</sup> - 36:16, 40:25, 48:18, 48:20, 49:1</p> <p><b>central</b> <sup>[4]</sup> - 70:20,</p>	<p>73:12, 73:15, 122:16</p> <p><b>certain</b> <sup>[3]</sup> - 27:9, 36:7, 56:23</p> <p><b>certainly</b> <sup>[7]</sup> - 25:12, 42:10, 47:15, 64:8, 96:16, 97:4, 151:1</p> <p><b>CERTIFICATION</b> <sup>[1]</sup> - 153:24</p> <p><b>certified</b> <sup>[1]</sup> - 112:12</p> <p><b>certify</b> <sup>[1]</sup> - 154:2</p> <p><b>chain</b> <sup>[9]</sup> - 11:9, 58:7, 60:1, 61:2, 66:20, 67:5, 67:8, 81:8, 120:14</p> <p><b>Chambers</b> <sup>[3]</sup> - 57:20, 67:11, 67:14</p> <p><b>chance</b> <sup>[2]</sup> - 54:13, 68:6</p> <p><b>change</b> <sup>[11]</sup> - 9:9, 18:4, 18:13, 25:3, 26:13, 26:14, 27:18, 42:25, 46:7, 83:8, 149:2</p> <p><b>changed</b> <sup>[14]</sup> - 9:10, 15:22, 20:14, 25:12, 25:13, 37:13, 42:14, 46:12, 46:15, 59:6, 59:7, 104:12, 105:5, 113:21</p> <p><b>changes</b> <sup>[9]</sup> - 74:11, 76:24, 119:25, 128:1, 148:13, 148:15, 148:20, 149:7, 150:2</p> <p><b>changing</b> <sup>[6]</sup> - 16:16, 21:16, 28:6, 29:2, 59:18, 105:16</p> <p><b>character</b> <sup>[1]</sup> - 153:12</p> <p><b>charged</b> <sup>[2]</sup> - 88:6, 149:24</p> <p><b>CHARLES</b> <sup>[1]</sup> - 3:11</p> <p><b>Charleston</b> <sup>[34]</sup> - 2:8, 3:13, 4:24, 5:15, 6:9, 7:4, 15:18, 46:22, 57:23, 81:1, 81:13, 82:3, 82:8, 82:9, 82:13, 82:23, 83:1, 83:15, 84:1, 84:13, 84:19, 86:12, 86:20, 86:23, 116:19, 116:22, 117:4, 117:11, 118:15, 120:11, 120:15, 136:18, 137:2, 137:6</p> <p><b>CHARLESTON</b> <sup>[2]</sup> - 1:2, 1:18</p> <p><b>chart</b> <sup>[11]</sup> - 11:22, 16:2, 16:3, 16:4, 19:22, 22:22, 27:23, 30:3, 30:5, 33:3,</p>	<p>65:4</p> <p><b>charts</b> <sup>[9]</sup> - 30:4, 32:25, 33:11, 34:21, 74:6, 108:17, 114:9, 145:15</p> <p><b>Chase</b> <sup>[1]</sup> - 4:23</p> <p><b>check</b> <sup>[4]</sup> - 23:6, 23:10, 108:24, 146:4</p> <p><b>checked</b> <sup>[1]</sup> - 112:12</p> <p><b>checkers</b> <sup>[1]</sup> - 40:23</p> <p><b>Chesterbrook</b> <sup>[1]</sup> - 6:15</p> <p><b>Chicago</b> <sup>[1]</sup> - 74:24</p> <p><b>Chief</b> <sup>[1]</sup> - 24:16</p> <p><b>chief</b> <sup>[2]</sup> - 39:15, 45:17</p> <p><b>child</b> <sup>[1]</sup> - 121:22</p> <p><b>China</b> <sup>[1]</sup> - 67:4</p> <p><b>chiropractors</b> <sup>[1]</sup> - 35:23</p> <p><b>choice</b> <sup>[1]</sup> - 152:18</p> <p><b>chose</b> <sup>[1]</sup> - 48:5</p> <p><b>Chris</b> <sup>[1]</sup> - 15:19</p> <p><b>Chronic</b> <sup>[1]</sup> - 23:4</p> <p><b>chronic</b> <sup>[6]</sup> - 16:21, 19:4, 19:5, 19:6, 32:2, 35:14</p> <p><b>Circuit</b> <sup>[1]</sup> - 104:14</p> <p><b>circumstances</b> <sup>[1]</sup> - 103:21</p> <p><b>cite</b> <sup>[2]</sup> - 49:9, 68:10</p> <p><b>cited</b> <sup>[2]</sup> - 67:14, 85:17</p> <p><b>Cities</b> <sup>[1]</sup> - 66:14</p> <p><b>cities</b> <sup>[2]</sup> - 68:12, 115:6</p> <p><b>citing</b> <sup>[1]</sup> - 84:24</p> <p><b>city</b> <sup>[8]</sup> - 29:18, 36:6, 36:7, 59:17, 59:20, 62:12, 68:20, 123:9</p> <p><b>City</b> <sup>[56]</sup> - 4:1, 5:11, 18:2, 18:10, 57:22, 68:18, 76:15, 80:25, 81:13, 82:3, 82:8, 82:9, 82:13, 82:22, 82:25, 83:15, 84:1, 84:13, 84:19, 86:12, 86:19, 86:22, 116:19, 116:22, 117:3, 117:11, 118:15, 120:11, 120:15, 122:24, 123:1, 123:8, 123:13, 124:4, 125:19, 130:3, 130:6, 130:8, 130:10, 130:14, 132:3, 133:5, 133:14, 133:17, 133:21, 133:23, 134:4, 134:9, 134:14, 134:16,</p>	<p>136:18, 137:1, 137:5, 139:3, 146:14, 154:3</p> <p><b>CITY</b> <sup>[1]</sup> - 1:4</p> <p><b>city's</b> <sup>[5]</sup> - 65:24, 66:2, 66:11, 66:13, 67:10</p> <p><b>Civil</b> <sup>[3]</sup> - 1:4, 154:5, 154:6</p> <p><b>civil</b> <sup>[1]</sup> - 1:10</p> <p><b>claim</b> <sup>[27]</sup> - 11:15, 59:5, 70:14, 72:7, 72:13, 73:2, 74:10, 89:15, 91:16, 91:24, 92:9, 92:15, 92:16, 93:6, 93:8, 93:25, 99:15, 101:17, 102:10, 102:17, 111:11, 111:18, 118:13, 121:3, 128:11, 135:3, 137:7</p> <p><b>claimed</b> <sup>[6]</sup> - 70:25, 72:17, 72:20, 81:5, 111:4, 121:10</p> <p><b>claiming</b> <sup>[3]</sup> - 93:6, 101:19, 123:4</p> <p><b>claims</b> <sup>[11]</sup> - 11:6, 81:2, 84:21, 86:11, 92:1, 93:16, 94:6, 99:17, 112:11, 116:23, 120:9</p> <p><b>class</b> <sup>[6]</sup> - 59:12, 92:22, 92:25, 93:3, 112:6, 112:10</p> <p><b>classic</b> <sup>[1]</sup> - 93:8</p> <p><b>classically</b> <sup>[1]</sup> - 103:14</p> <p><b>cleanse</b> <sup>[1]</sup> - 152:1</p> <p><b>clear</b> <sup>[10]</sup> - 19:14, 19:24, 26:4, 57:17, 58:2, 87:17, 102:7, 103:9, 110:11, 141:18</p> <p><b>cleared</b> <sup>[1]</sup> - 49:24</p> <p><b>clearly</b> <sup>[29]</sup> - 39:18, 73:21, 74:13, 74:25, 75:7, 75:10, 75:22, 77:3, 77:23, 78:2, 78:16, 79:16, 80:8, 82:24, 84:9, 84:13, 90:6, 92:17, 93:17, 104:5, 109:24, 114:10, 121:4, 121:5, 122:23, 128:18, 136:9, 144:5</p> <p><b>clerical</b> <sup>[1]</sup> - 146:5</p> <p><b>climb</b> <sup>[1]</sup> - 74:7</p> <p><b>Clinic</b> <sup>[1]</sup> - 23:4</p> <p><b>clinics</b> <sup>[2]</sup> - 23:15, 100:23</p> <p><b>clip</b> <sup>[3]</sup> - 41:20, 41:22,</p>	<p>42:5</p> <p><b>close</b> <sup>[1]</sup> - 97:24</p> <p><b>Closed</b> <sup>[1]</sup> - 79:9</p> <p><b>closed</b> <sup>[7]</sup> - 79:10, 80:17, 81:8, 143:2, 143:20, 145:2, 151:4</p> <p><b>closing</b> <sup>[9]</sup> - 55:15, 62:3, 73:6, 73:10, 99:24, 128:3, 139:12, 141:22, 151:5</p> <p><b>closings</b> <sup>[5]</sup> - 47:4, 73:14, 96:2, 116:9, 120:25</p> <p><b>co</b> <sup>[1]</sup> - 147:7</p> <p><b>co-counsel</b> <sup>[1]</sup> - 147:7</p> <p><b>coal</b> <sup>[5]</sup> - 60:14, 85:22, 85:24, 86:2, 86:3</p> <p><b>cocaine</b> <sup>[1]</sup> - 64:4</p> <p><b>Cochran</b> <sup>[3]</sup> - 6:17, 153:25, 154:9</p> <p><b>Code</b> <sup>[2]</sup> - 149:25</p> <p><b>code</b> <sup>[1]</sup> - 103:2</p> <p><b>codes</b> <sup>[1]</sup> - 29:16</p> <p><b>codified</b> <sup>[1]</sup> - 143:1</p> <p><b>coin</b> <sup>[4]</sup> - 14:15, 14:16, 15:1, 116:7</p> <p><b>colleague</b> <sup>[1]</sup> - 60:21</p> <p><b>colleagues</b> <sup>[5]</sup> - 38:25, 43:15, 60:20, 139:3, 152:21</p> <p><b>colorful</b> <sup>[1]</sup> - 116:9</p> <p><b>colorfully</b> <sup>[2]</sup> - 114:24, 130:3</p> <p><b>Colston</b> <sup>[5]</sup> - 64:22, 129:13, 134:8, 150:20</p> <p><b>coming</b> <sup>[3]</sup> - 9:22, 29:8, 36:20</p> <p><b>Coming</b> <sup>[1]</sup> - 58:13</p> <p><b>comment</b> <sup>[1]</sup> - 145:5</p> <p><b>commented</b> <sup>[1]</sup> - 139:13</p> <p><b>comments</b> <sup>[1]</sup> - 147:18</p> <p><b>COMMISSION</b> <sup>[1]</sup> - 1:10</p> <p><b>Commission</b> <sup>[18]</sup> - 2:2, 3:2, 17:22, 17:25, 18:11, 57:20, 58:6, 59:18, 59:20, 67:10, 83:3, 83:8, 83:12, 83:17, 83:19, 89:5, 132:4, 139:4</p> <p><b>Commissioner</b> <sup>[1]</sup> - 24:19</p> <p><b>committee</b> <sup>[2]</sup> - 47:17, 65:17</p> <p><b>Committee</b> <sup>[1]</sup> - 47:18</p> <p><b>common</b> <sup>[11]</sup> - 16:21,</p>
---	---	--	---	--

<p>64:13, 78:18, 89:25, 93:2, 93:14, 119:14, 129:15, 146:2 <u>commonality</u> [1] - 92:25 <u>community</u> [32] - 17:9, 23:17, 25:4, 25:25, 69:12, 70:22, 77:10, 79:4, 79:5, 79:8, 88:10, 89:4, 89:14, 100:22, 101:23, 110:7, 110:10, 114:6, 125:14, 125:24, 126:6, 126:15, 128:20, 129:19, 129:24, 132:25, 133:12, 135:6, 137:10, 150:6, 151:3, 152:2 <u>Comp</u> [1] - 35:19 <u>companies</u> [6] - 41:12, 85:23, 85:24, 86:2, 97:23, 144:19 <u>company</u> [4] - 13:1, 13:2, 40:9, 45:23 <u>company's</u> [1] - 45:21 <u>comparable</u> [1] - 131:3 <u>compared</u> [6] - 8:18, 33:15, 34:16, 40:17, 127:7, 131:14 <u>compels</u> [1] - 69:16 <u>competence</u> [1] - 153:13 <u>compiled</u> [1] - 127:14 <u>complained</u> [1] - 61:19 <u>complaint</u> [4] - 22:2, 46:6, 59:6, 59:10 <u>complaints</u> [1] - 47:2 <u>complete</u> [5] - 14:4, 47:8, 118:12, 118:16, 134:12 <u>completely</u> [7] - 12:6, 37:10, 41:7, 61:21, 98:24, 103:19, 126:22 <u>complex</u> [1] - 143:3 <u>compliance</u> [1] - 110:17 <u>compliant</u> [2] - 42:2, 42:3 <u>complicated</u> [1] - 112:16 <u>complied</u> [1] - 43:5 <u>comply</u> [3] - 43:16, 47:15, 50:21 <u>complying</u> [1] - 100:19</p>	<p><u>component</u> [9] - 40:22, 44:17, 47:12, 47:13, 47:14, 84:9, 84:11, 150:15 <u>components</u> [5] - 40:13, 44:15, 45:11, 47:9, 55:3 <u>Compton</u> [3] - 78:3, 115:12, 119:20 <u>computer</u> [2] - 6:19, 40:17 <u>conceded</u> [5] - 49:23, 50:2, 50:7, 50:20, 51:5 <u>concept</u> [5] - 17:9, 83:4, 93:8, 122:10, 139:17 <u>concern</u> [2] - 20:22, 91:3 <u>concerns</u> [3] - 44:21, 46:4, 54:8 <u>concession</u> [1] - 30:20 <u>conclude</u> [4] - 73:7, 111:3, 138:7 <u>concluded</u> [6] - 22:13, 42:5, 65:8, 76:9, 83:11, 100:13 <u>conclusion</u> [5] - 30:22, 70:16, 73:17, 120:15, 145:16 <u>conclusions</u> [5] - 8:22, 57:13, 73:16, 119:22, 152:11 <u>conclusive</u> [4] - 73:18, 75:20, 76:6, 76:25 <u>conditions</u> [5] - 33:25, 34:16, 34:20, 35:5, 36:7 <u>conduct</u> [35] - 7:16, 7:19, 8:2, 8:8, 8:19, 9:2, 11:1, 11:4, 11:7, 11:16, 11:21, 12:2, 12:4, 26:9, 33:18, 48:12, 57:6, 61:19, 63:2, 71:17, 72:20, 80:15, 81:6, 82:11, 83:14, 85:2, 89:18, 90:2, 120:22, 121:8, 121:17, 122:4, 122:14, 135:16 <u>conduct</u> [1] - 122:9 <u>conducted</u> [3] - 108:23, 109:1, 109:13 <u>conference</u> [4] - 42:20, 43:9, 43:25, 44:14 <u>confirmed</u> [2] - 25:2,</p>	<p>53:20 <u>confirms</u> [1] - 79:13 <u>Congress</u> [2] - 98:25, 143:12 <u>connection</u> [1] - 48:9 <u>Connolly</u> [2] - 4:18, 5:4 <u>CONROY</u> [1] - 3:3 <u>consequence</u> [3] - 21:11, 57:6, 116:2 <u>consequences</u> [1] - 81:7 <u>conservative</u> [1] - 23:18 <u>consider</u> [2] - 131:22, 132:9 <u>consideration</u> [1] - 138:9 <u>considered</u> [1] - 131:23 <u>consistent</u> [5] - 30:23, 41:7, 42:12, 64:8, 94:2 <u>consistently</u> [2] - 100:18, 143:13 <u>consolidate</u> [1] - 112:9 <u>consolidated</u> [1] - 112:18 <u>conspiracy</u> [1] - 141:2 <u>constituted</u> [1] - 20:12 <u>constraint</u> [1] - 125:23 <u>consult</u> [1] - 70:5 <u>consultation</u> [2] - 87:19, 87:25 <u>consumption</u> [1] - 140:11 <u>contains</u> [2] - 17:14, 52:11 <u>contest</u> [1] - 96:6 <u>context</u> [4] - 13:13, 49:6, 54:23, 57:8 <u>continually</u> [2] - 87:18, 117:23 <u>continue</u> [4] - 49:9, 68:24, 89:11, 139:24 <u>continued</u> [5] - 15:24, 20:5, 21:4, 126:9, 126:10 <u>Continued</u> [5] - 3:1, 5:1, 5:6, 6:1, 6:10 <u>continuing</u> [4] - 21:17, 47:23, 104:8, 144:19 <u>contradicted</u> [2] - 65:12, 108:24 <u>contradiction</u> [1] - 136:9 <u>contradicts</u> [2] - 102:21, 125:18 <u>contrary</u> [5] - 31:22,</p>	<p>100:11, 100:12, 109:11, 116:12 <u>contrast</u> [3] - 35:24, 100:24 <u>contribute</u> [1] - 111:17 <u>contributed</u> [2] - 101:20, 111:6 <u>contributes</u> [1] - 91:14 <u>control</u> [17] - 59:3, 61:12, 71:4, 79:13, 79:16, 79:18, 79:23, 80:2, 80:13, 136:15, 139:15, 143:6, 143:23, 143:24, 144:9, 149:16, 150:1 <u>Controlled</u> [2] - 23:3, 42:2 <u>controlled</u> [12] - 23:13, 36:19, 36:22, 37:1, 37:23, 52:19, 77:7, 90:8, 91:4, 139:18, 139:23, 142:19 <u>controlling</u> [2] - 136:16, 150:11 <u>controls</u> [1] - 110:18 <u>convenience</u> [1] - 89:19 <u>convicted</u> [3] - 141:1, 141:24 <u>convince</u> [1] - 147:16 <u>Cook</u> [3] - 6:18, 154:1, 154:9 <u>cooperate</u> [1] - 142:6 <u>COPD</u> [1] - 34:24 <u>Copenhaver</u> [8] - 57:7, 57:11, 57:19, 58:2, 67:9, 67:16, 83:7, 83:24 <u>copy</u> [2] - 19:17, 21:20 <u>core</u> [7] - 77:16, 99:18, 101:18, 109:14, 109:15, 120:18, 121:2 <u>Corey</u> [1] - 25:1 <u>cORPORATION</u> [2] - 1:7, 1:13 <u>Corporation</u> [2] - 6:2, 154:5 <u>Corps</u> [1] - 149:5 <u>correct</u> [5] - 88:4, 117:8, 142:23, 142:24, 154:2 <u>correctly</u> [1] - 93:11 <u>correlation</u> [1] - 65:7 <u>cost</u> [3] - 78:1, 126:21, 133:4 <u>costs</u> [6] - 121:5,</p>	<p>123:17, 123:19, 126:2, 126:4, 127:10 <u>counsel</u> [1] - 147:7 <u>counteracted</u> [1] - 137:18 <u>counterparts</u> [1] - 35:7 <u>counties</u> [2] - 36:11, 68:12 <u>counting</u> [1] - 7:19 <u>country</u> [14] - 17:23, 23:18, 28:19, 34:7, 34:8, 34:17, 37:14, 37:22, 40:12, 44:11, 87:23, 92:3, 118:9, 128:17 <u>country's</u> [2] - 15:17, 64:23 <u>county</u> [2] - 29:18, 68:21 <u>COUNTY</u> [1] - 1:10 <u>County</u> [43] - 2:2, 3:2, 7:12, 29:25, 30:14, 32:8, 32:11, 37:18, 37:24, 48:12, 55:24, 56:7, 62:8, 75:17, 76:17, 98:10, 106:2, 122:24, 123:2, 124:5, 125:19, 129:2, 130:3, 130:8, 132:4, 133:5, 133:14, 133:17, 133:21, 133:24, 134:4, 134:10, 134:14, 134:16, 139:4, 144:3, 145:18, 146:13, 146:14, 147:3, 148:22, 149:6, 150:18 <u>County's</u> [1] - 37:25 <u>couple</u> [3] - 40:13, 100:1, 139:9 <u>course</u> [14] - 8:20, 22:23, 31:19, 35:5, 36:16, 59:16, 66:9, 68:23, 83:19, 95:1, 102:6, 115:7, 115:18, 118:17 <u>court</u> [3] - 124:3, 134:15, 139:13 <u>Court</u> [82] - 6:17, 6:18, 7:3, 7:18, 9:2, 11:13, 12:3, 15:7, 17:13, 26:8, 31:12, 38:5, 40:1, 41:9, 49:15, 56:5, 57:17, 63:5, 67:24, 68:14, 70:4, 73:5, 73:7, 73:13, 75:4, 75:24, 76:7,</p>
--	---	--	---	--



76:24, 83:2, 84:2,  
84:5, 84:15, 84:16,  
85:13, 85:17, 85:23,  
86:16, 87:11, 91:11,  
91:14, 91:25, 93:20,  
93:22, 101:12,  
103:13, 104:7,  
107:18, 108:17,  
111:2, 112:14,  
114:21, 116:25,  
119:8, 120:8,  
121:21, 123:15,  
124:3, 124:19,  
124:21, 125:12,  
130:1, 130:20,  
134:21, 134:22,  
134:25, 135:21,  
135:22, 135:23,  
136:5, 136:21,  
138:8, 138:12,  
140:6, 141:3,  
141:14, 141:21,  
142:11, 142:13,  
153:18, 153:25,  
154:1  
**COURT** [50] - 1:1,  
1:17, 7:6, 10:8,  
10:11, 13:8, 14:18,  
14:24, 19:19, 38:12,  
38:16, 38:20, 39:4,  
39:7, 39:21, 69:22,  
70:5, 70:11, 70:13,  
86:17, 86:21, 87:1,  
92:21, 93:9, 96:12,  
97:6, 111:21,  
111:24, 112:1,  
138:14, 138:16,  
138:19, 138:22,  
138:24, 140:14,  
142:4, 142:20,  
142:22, 143:8,  
146:12, 146:19,  
146:25, 147:23,  
148:8, 152:9,  
152:15, 152:18,  
153:7, 153:10,  
153:17  
**Court's** [3] - 83:21,  
135:20, 139:10  
**court-administered**  
[1] - 134:15  
**Court-supervised** [1]  
- 124:19  
**courtesies** [2] - 69:20,  
138:10  
**Courtright** [2] -  
142:25  
**courtroom** [4] - 69:1,  
69:3, 138:10, 144:19  
**courts** [2] - 68:2,

91:25  
**cover** [7] - 8:3, 11:23,  
13:17, 47:7, 62:11,  
63:5, 67:20  
**coverage** [1] - 35:23  
**covered** [4] - 35:24,  
45:22, 54:21, 55:2  
**covers** [1] - 123:16  
**Covington** [1] - 5:11  
**crack** [1] - 64:4  
**Cranberry** [1] - 147:24  
**create** [7] - 44:10,  
45:8, 80:13, 124:21,  
135:18, 139:21,  
140:10  
**created** [4] - 77:18,  
107:22, 113:11,  
143:1  
**creating** [1] - 124:10  
**credibility** [2] -  
126:18, 145:7  
**credible** [1] - 49:14  
**credit** [2] - 28:7, 30:20  
**credited** [1] - 107:21  
**crime** [7] - 61:4, 61:5,  
61:7, 115:25, 116:1,  
116:3, 116:5  
**crimes** [1] - 82:21  
**criminal** [23] - 58:7,  
61:18, 71:7, 72:23,  
77:19, 80:14, 82:11,  
82:14, 82:18, 82:22,  
83:16, 85:5, 115:20,  
115:21, 116:13,  
116:14, 116:24,  
117:1, 120:6,  
136:14, 137:4,  
141:2, 141:17  
**crisis** [19] - 59:21,  
64:24, 71:24, 71:25,  
73:9, 81:24, 81:25,  
102:13, 113:11,  
113:23, 113:25,  
114:16, 118:7,  
118:11, 124:8,  
133:18, 134:4,  
134:6, 134:17  
**criteria** [2] - 47:14,  
125:4  
**critical** [7] - 10:17,  
68:13, 72:19, 73:17,  
73:22, 90:3  
**criticize** [1] - 147:12  
**criticized** [1] - 146:17  
**cross** [5] - 13:23,  
30:10, 30:11, 35:10,  
54:13  
**cross-examination** [1]  
- 13:23  
**cross-examine** [1] -

54:13  
**cross-examined** [1] -  
35:10  
**CRR** [2] - 6:17, 6:18  
**cry** [1] - 116:16  
**cull** [1] - 87:14  
**culled** [1] - 137:1  
**culture** [3] - 24:25,  
74:15, 74:17  
**current** [4] - 48:2,  
71:24, 128:23,  
129:21  
**curve** [1] - 19:2  
**Custom** [1] - 100:21  
**customer** [13] - 9:1,  
40:18, 44:20, 44:24,  
45:4, 52:9, 52:12,  
52:22, 53:9, 69:4,  
69:6, 69:7, 100:20  
**Customer** [3] - 44:17,  
47:12, 51:21  
**customer's** [1] - 40:19  
**customers** [29] -  
12:18, 40:14, 40:25,  
44:18, 44:19, 44:21,  
46:15, 47:21, 47:24,  
49:6, 49:7, 51:21,  
51:24, 54:4, 55:25,  
60:9, 71:18, 95:19,  
95:21, 98:13, 99:22,  
99:25, 100:1, 100:3,  
100:4, 100:14,  
100:18, 105:15,  
109:13  
**customized** [1] -  
44:23  
**cut** [4] - 9:17, 9:23,  
56:2, 56:4  
**cuts** [2] - 62:13, 65:25

## D

**daily** [1] - 51:1  
**dam** [4] - 148:7,  
148:13, 149:13,  
150:22  
**damages** [5] - 121:4,  
121:5, 128:12,  
135:2, 135:12  
**dangerous** [3] - 92:19,  
94:13, 95:9  
**data** [12] - 29:17,  
36:25, 46:12, 52:23,  
53:1, 65:6, 75:18,  
75:19, 96:4, 127:13,  
127:14, 127:15  
**database** [5] - 23:6,  
23:11, 102:25,  
106:10, 106:12  
**date** [1] - 45:16

**dated** [1] - 43:12  
**dates** [1] - 62:12  
**Daubert** [1] - 49:11  
**DAVID** [2] - 1:17, 4:5  
**David** [1] - 7:1  
**days** [17] - 7:18,  
12:20, 12:25, 13:1,  
43:12, 74:14, 78:17,  
78:18, 79:19, 79:22,  
81:16, 88:14,  
127:17, 127:18,  
127:23  
**DC** [6] - 4:7, 4:10,  
4:19, 4:21, 5:5, 5:12  
**De** [2] - 2:4, 2:14  
**DEA** [105] - 9:14,  
12:13, 12:17, 18:13,  
18:14, 18:17, 20:21,  
27:17, 27:19, 27:22,  
28:2, 28:10, 28:13,  
28:21, 28:23, 29:3,  
29:14, 29:19, 31:16,  
33:3, 33:8, 36:23,  
37:1, 37:6, 40:15,  
40:21, 41:2, 41:6,  
41:8, 41:10, 41:16,  
42:1, 42:12, 42:14,  
42:19, 42:22, 43:1,  
43:3, 43:11, 43:15,  
43:18, 45:5, 45:11,  
45:16, 46:3, 46:6,  
46:9, 46:10, 46:11,  
47:10, 47:16, 48:1,  
48:3, 48:14, 48:24,  
48:25, 49:4, 50:4,  
50:17, 54:18, 55:21,  
56:4, 56:18, 56:19,  
59:2, 61:2, 76:9,  
77:4, 87:17, 87:21,  
88:2, 88:3, 88:5,  
89:5, 100:9, 103:1,  
104:10, 104:12,  
104:19, 104:23,  
104:24, 104:25,  
105:1, 105:2, 105:4,  
105:21, 106:1,  
106:5, 106:8,  
106:10, 106:18,  
107:22, 108:2,  
110:13, 111:16,  
117:22, 137:24,  
143:8, 143:11,  
143:12, 144:12,  
144:14  
**DEA's** [5] - 36:21,  
45:18, 103:24,  
105:16, 108:7  
**dealer** [1] - 67:4  
**dealers** [9] - 61:19,  
66:1, 66:4, 66:12,

82:19, 101:22,  
114:23, 115:4,  
116:14  
**Dean** [1] - 60:22  
**death** [1] - 65:10  
**deaths** [4] - 65:3,  
132:23, 133:2, 133:9  
**debate** [2] - 25:24,  
139:8  
**decade** [7] - 15:24,  
61:19, 89:10, 109:3,  
109:6, 109:10,  
113:18  
**December** [2] - 44:1,  
53:21  
**deceptive** [2] - 59:11,  
59:15  
**decide** [7] - 26:7, 27:8,  
55:20, 60:15, 74:21,  
75:25, 136:20  
**decided** [8] - 9:15,  
55:21, 74:22, 84:2,  
88:6, 117:3, 136:23,  
137:11  
**decides** [1] - 79:19  
**deciding** [2] - 26:5,  
134:24  
**decision** [10] - 26:20,  
27:3, 27:6, 79:25,  
93:19, 104:14,  
104:16, 117:4,  
135:21, 136:22  
**decisions** [18] - 70:23,  
71:6, 71:14, 72:22,  
76:23, 77:2, 77:13,  
78:20, 81:4, 81:9,  
81:10, 82:9, 87:4,  
90:17, 90:23,  
115:19, 136:13,  
137:16  
**decline** [3] - 112:24,  
113:9, 113:10  
**declined** [1] - 113:1  
**deemed** [3] - 89:24,  
94:13, 142:17  
**deep** [1] - 138:8  
**Deer** [19] - 15:9, 15:14,  
15:18, 15:20, 16:3,  
16:20, 17:13, 17:24,  
20:25, 21:8, 21:16,  
22:10, 22:13, 23:25,  
24:14, 34:4, 35:3,  
35:13, 35:17  
**Deer's** [1] - 27:20  
**defeat** [3] - 82:22,  
83:16, 85:4  
**defeated** [4] - 72:22,  
81:11, 82:11, 83:14  
**defeating** [1] - 137:3  
**defeats** [6] - 71:9,

<p>86:11, 99:14, 133:11, 136:24, 137:7</p> <p><b>defend</b> [1] - 146:23</p> <p><b>Defendant</b> [4] - 4:16, 5:2, 5:7, 6:2</p> <p><b>defendant</b> [3] - 57:18, 83:2, 101:13</p> <p><b>Defendants</b> [3] - 1:8, 1:14, 154:5</p> <p><b>defendants</b> [20] - 7:13, 7:15, 73:8, 83:1, 101:5, 102:3, 122:4, 122:13, 122:20, 124:22, 128:4, 143:13, 143:23, 145:7, 145:10, 147:14, 148:19, 149:12, 150:25</p> <p><b>defendants'</b> [6] - 26:9, 59:11, 72:20, 102:22, 122:9, 122:14</p> <p><b>defense</b> [8] - 69:17, 141:9, 141:10, 141:20, 141:22, 141:25, 144:25</p> <p><b>defies</b> [1] - 151:3</p> <p><b>define</b> [1] - 151:22</p> <p><b>defined</b> [1] - 139:18</p> <p><b>defining</b> [1] - 103:15</p> <p><b>definition</b> [1] - 56:12</p> <p><b>delivered</b> [1] - 150:7</p> <p><b>delivery</b> [2] - 115:14, 144:1</p> <p><b>delivery-like</b> [1] - 115:14</p> <p><b>demand</b> [14] - 10:7, 10:16, 10:20, 39:2, 39:14, 75:5, 75:8, 75:11, 75:12, 139:16, 139:21, 140:11, 140:12</p> <p><b>demanding</b> [1] - 35:7</p> <p><b>demands</b> [2] - 89:19, 137:12</p> <p><b>demonstrably</b> [1] - 136:2</p> <p><b>demonstrate</b> [3] - 146:16, 146:18, 147:3</p> <p><b>demonstrated</b> [1] - 125:10</p> <p><b>demonstrates</b> [7] - 84:3, 92:5, 92:8, 95:4, 95:9, 116:20, 138:5</p> <p><b>denied</b> [3] - 9:19, 91:25, 144:8</p>	<p><b>denying</b> [1] - 72:9</p> <p><b>Department</b> [1] - 101:8</p> <p><b>depo</b> [1] - 41:9</p> <p><b>deposition</b> [1] - 41:9</p> <p><b>depression</b> [1] - 35:1</p> <p><b>depth</b> [1] - 70:18</p> <p><b>Deputy</b> [2] - 78:3, 119:20</p> <p><b>described</b> [5] - 30:5, 115:9, 119:17, 130:6, 130:25</p> <p><b>description</b> [2] - 131:13</p> <p><b>design</b> [1] - 150:16</p> <p><b>designation</b> [2] - 41:9, 41:10</p> <p><b>designed</b> [1] - 143:11</p> <p><b>detail</b> [5] - 8:4, 45:21, 72:15, 108:11, 111:2</p> <p><b>detailed</b> [1] - 44:17</p> <p><b>detect</b> [1] - 145:12</p> <p><b>detecting</b> [1] - 107:24</p> <p><b>determination</b> [2] - 25:10, 77:6</p> <p><b>determinations</b> [1] - 110:21</p> <p><b>determine</b> [2] - 52:15, 71:6</p> <p><b>determined</b> [4] - 40:18, 75:2, 75:15, 89:23</p> <p><b>determines</b> [3] - 10:21, 75:3, 76:4</p> <p><b>determining</b> [1] - 125:4</p> <p><b>Detroit</b> [5] - 67:4, 114:25, 115:3, 115:4, 115:6</p> <p><b>develop</b> [1] - 121:20</p> <p><b>developed</b> [7] - 42:18, 83:4, 92:13, 101:24, 125:14, 129:11, 130:22</p> <p><b>development</b> [1] - 83:20</p> <p><b>develops</b> [3] - 116:2, 121:25</p> <p><b>deviated</b> [3] - 130:18, 131:19, 132:12</p> <p><b>deviating</b> [2] - 103:16, 144:6</p> <p><b>deviation</b> [1] - 131:18</p> <p><b>devote</b> [1] - 123:2</p> <p><b>devour</b> [1] - 94:10</p> <p><b>diabetes</b> [1] - 34:25</p> <p><b>dice</b> [1] - 51:2</p> <p><b>difference</b> [2] - 149:21, 151:24</p> <p><b>differences</b> [1] -</p>	<p>148:17</p> <p><b>different</b> [18] - 13:18, 51:8, 53:1, 55:11, 56:25, 57:23, 57:24, 64:10, 84:15, 96:14, 97:9, 103:11, 112:22, 130:21, 136:2, 136:3, 142:7, 148:23</p> <p><b>difficult</b> [1] - 139:2</p> <p><b>digit</b> [2] - 29:15, 103:2</p> <p><b>diligence</b> [30] - 40:14, 44:18, 44:19, 47:22, 49:19, 51:9, 51:13, 51:16, 51:18, 51:20, 51:21, 52:3, 52:4, 52:7, 53:2, 53:9, 56:14, 56:17, 69:9, 105:15, 108:10, 108:23, 109:1, 109:3, 109:6, 109:8, 109:10, 109:11, 109:12</p> <p><b>dimension</b> [1] - 11:15</p> <p><b>Direct</b> [3] - 140:4, 140:6, 144:25</p> <p><b>direct</b> [12] - 11:13, 19:7, 57:5, 57:18, 72:16, 81:5, 81:7, 83:18, 102:8, 109:11, 118:18, 122:8</p> <p><b>directed</b> [2] - 89:7, 98:8</p> <p><b>direction</b> [1] - 23:1</p> <p><b>directly</b> [6] - 90:10, 102:21, 109:14, 122:11, 125:17, 137:6</p> <p><b>Director</b> [3] - 78:3, 119:20, 119:21</p> <p><b>disagree</b> [3] - 10:8, 10:12, 10:14</p> <p><b>disappeared</b> [1] - 113:4</p> <p><b>disburses</b> [1] - 124:21</p> <p><b>disciplinary</b> [3] - 19:15, 19:25, 22:9</p> <p><b>discipline</b> [2] - 19:4, 20:13</p> <p><b>disciplined</b> [2] - 37:17, 69:8</p> <p><b>disclaimed</b> [1] - 107:25</p> <p><b>disconnect</b> [1] - 68:15</p> <p><b>discretion</b> [1] - 134:24</p> <p><b>discuss</b> [3] - 70:17, 95:15, 147:6</p> <p><b>discussed</b> [15] - 11:11, 51:25, 72:18,</p>	<p>77:15, 82:17, 86:10, 90:12, 92:4, 94:3, 101:16, 110:24, 117:9, 125:8, 127:13, 128:8</p> <p><b>discussion</b> [4] - 75:14, 88:13, 113:19, 115:23</p> <p><b>discussions</b> [1] - 43:20</p> <p><b>disease</b> [1] - 34:23</p> <p><b>dismiss</b> [4] - 67:10, 84:2, 91:25, 92:2</p> <p><b>dismissed</b> [2] - 57:9, 139:17</p> <p><b>dismissing</b> [1] - 81:2</p> <p><b>disorder</b> [1] - 64:25</p> <p><b>disparaged</b> [1] - 145:7</p> <p><b>dispense</b> [2] - 60:4, 91:3</p> <p><b>dispensed</b> [10] - 66:24, 71:3, 79:6, 79:7, 82:18, 101:6, 102:1, 109:20, 110:6, 111:12</p> <p><b>dispenses</b> [1] - 100:14</p> <p><b>dispensing</b> [4] - 11:10, 55:22, 140:8, 140:24</p> <p><b>dispositive</b> [1] - 68:4</p> <p><b>dispute</b> [4] - 7:10, 26:12, 26:14, 143:22</p> <p><b>disputed</b> [3] - 31:20, 38:4, 69:16</p> <p><b>disputes</b> [1] - 143:21</p> <p><b>disputing</b> [1] - 7:14</p> <p><b>disregarded</b> [1] - 137:18</p> <p><b>distinction</b> [2] - 105:11, 151:23</p> <p><b>distinguish</b> [1] - 67:17</p> <p><b>distinguished</b> [1] - 83:1</p> <p><b>distinguishing</b> [1] - 81:7</p> <p><b>distribute</b> [9] - 12:11, 75:1, 90:20, 96:3, 110:15, 122:22, 137:8, 143:20</p> <p><b>distributed</b> [5] - 8:18, 13:24, 15:4, 38:2, 61:17</p> <p><b>distributes</b> [1] - 12:7</p> <p><b>distributing</b> [1] - 98:1</p> <p><b>Distribution</b> [1] - 79:10</p> <p><b>distribution</b> [23] - 12:14, 12:15, 13:19, 27:21, 28:1, 33:20,</p>	<p>38:6, 39:13, 40:25, 41:2, 41:3, 48:18, 48:19, 48:22, 49:1, 49:3, 65:2, 72:3, 89:22, 90:3, 93:23, 101:14, 121:11</p> <p><b>distributions</b> [22] - 13:21, 14:5, 14:15, 15:1, 16:7, 16:9, 16:11, 16:16, 22:23, 24:9, 30:6, 30:14, 32:17, 32:24, 33:1, 33:2, 33:5, 33:7, 37:24, 95:15, 96:5, 121:13</p> <p><b>distributor</b> [17] - 37:1, 50:17, 56:2, 56:3, 61:11, 77:6, 77:8, 79:18, 79:22, 80:9, 80:10, 97:16, 99:4, 101:2, 104:3, 104:4, 140:16</p> <p><b>distributors</b> [75] - 10:22, 14:6, 23:12, 25:22, 26:14, 27:5, 27:13, 29:22, 36:23, 41:7, 42:9, 42:10, 43:2, 46:9, 50:13, 55:24, 56:10, 58:3, 58:4, 59:7, 65:16, 65:21, 66:8, 66:15, 71:3, 71:13, 71:20, 71:21, 73:4, 74:12, 74:20, 75:1, 75:20, 75:22, 76:3, 76:22, 77:1, 77:5, 77:13, 79:13, 79:16, 80:2, 80:4, 80:13, 83:1, 83:9, 83:10, 83:18, 83:23, 89:16, 90:14, 90:19, 90:23, 91:1, 92:3, 95:11, 97:21, 102:3, 104:20, 110:25, 114:15, 114:23, 115:18, 117:15, 118:8, 120:5, 135:17, 136:15, 137:16, 138:3, 139:14, 143:23, 149:22, 150:7</p> <p><b>Distributors</b> [1] - 27:8</p> <p><b>distributors'</b> [5] - 16:13, 85:2, 102:17, 120:22, 135:16</p> <p><b>district</b> [2] - 81:2, 86:14</p> <p><b>DISTRICT</b> [3] - 1:1, 1:1, 1:17</p> <p><b>District</b> [3] - 7:2, 7:3,</p>
---	--	--	--	--

<p>104:6</p> <p><b>divergence</b> [2] -</p> <p>126:20, 127:8</p> <p><b>diversion</b> [58] - 20:23,</p> <p>41:10, 44:3, 44:21,</p> <p>45:2, 46:18, 47:19,</p> <p>52:12, 52:13, 53:17,</p> <p>53:19, 54:1, 54:4,</p> <p>54:9, 58:15, 59:25,</p> <p>60:25, 61:10, 66:7,</p> <p>71:1, 71:4, 71:17,</p> <p>71:23, 72:23, 77:18,</p> <p>77:20, 78:7, 79:6,</p> <p>80:3, 80:12, 80:14,</p> <p>80:22, 82:17, 82:19,</p> <p>82:21, 85:6, 95:18,</p> <p>96:9, 96:13, 96:17,</p> <p>96:23, 97:3, 97:14,</p> <p>98:23, 100:6,</p> <p>101:10, 102:19,</p> <p>102:21, 105:14,</p> <p>107:5, 107:12,</p> <p>107:14, 110:13,</p> <p>110:19, 136:12,</p> <p>137:5, 141:17,</p> <p>142:18</p> <p><b>divert</b> [2] - 60:5, 80:15</p> <p><b>diverted</b> [20] - 50:10,</p> <p>61:6, 71:8, 71:21,</p> <p>77:21, 77:25, 78:13,</p> <p>78:15, 78:23, 79:9,</p> <p>79:24, 103:8,</p> <p>103:10, 103:11,</p> <p>103:22, 104:2,</p> <p>106:25, 107:1,</p> <p>107:10, 108:8</p> <p><b>diverting</b> [3] - 11:11,</p> <p>12:19, 69:7</p> <p><b>Division</b> [2] - 106:11,</p> <p>106:15</p> <p><b>dixit</b> [1] - 8:22</p> <p><b>Doctor</b> [1] - 140:24</p> <p><b>doctor</b> [24] - 20:13,</p> <p>21:2, 22:1, 22:8,</p> <p>23:7, 23:13, 25:9,</p> <p>60:3, 66:23, 76:2,</p> <p>77:16, 79:7, 79:19,</p> <p>80:5, 81:23, 85:3,</p> <p>88:22, 89:23,</p> <p>109:19, 110:11,</p> <p>116:17, 136:10,</p> <p>141:13, 141:24</p> <p><b>doctor's</b> [3] - 27:15,</p> <p>79:25, 82:5</p> <p><b>doctor-shopping</b> [1] -</p> <p>23:7</p> <p><b>doctors</b> [113] - 9:10,</p> <p>9:13, 9:23, 10:1,</p> <p>11:10, 12:9, 15:5,</p> <p>15:12, 17:3, 18:5,</p>	<p>18:6, 19:3, 19:4,</p> <p>19:13, 19:23, 20:7,</p> <p>20:10, 20:16, 20:18,</p> <p>21:8, 21:17, 21:23,</p> <p>21:24, 22:6, 22:11,</p> <p>22:16, 22:20, 23:6,</p> <p>23:8, 23:10, 23:25,</p> <p>24:7, 24:21, 25:17,</p> <p>25:19, 26:20, 27:2,</p> <p>27:15, 28:19, 28:22,</p> <p>31:14, 31:24, 32:1,</p> <p>32:4, 32:11, 34:9,</p> <p>37:11, 38:3, 56:6,</p> <p>58:8, 59:1, 60:15,</p> <p>66:8, 67:16, 71:6,</p> <p>71:11, 72:22, 73:11,</p> <p>73:12, 73:19, 74:3,</p> <p>74:11, 74:20, 74:22,</p> <p>74:25, 75:8, 75:21,</p> <p>75:23, 76:2, 76:12,</p> <p>76:13, 76:16, 76:20,</p> <p>77:2, 77:10, 77:11,</p> <p>77:13, 78:20, 81:10,</p> <p>83:16, 87:14, 87:15,</p> <p>88:16, 89:1, 89:4,</p> <p>89:14, 89:17, 90:4,</p> <p>90:14, 90:17, 90:20,</p> <p>91:2, 91:19, 94:21,</p> <p>95:2, 95:7, 95:12,</p> <p>95:13, 101:21,</p> <p>101:25, 110:5,</p> <p>111:1, 117:20,</p> <p>118:4, 136:13,</p> <p>137:1, 137:9,</p> <p>137:15, 137:19,</p> <p>138:2, 143:16,</p> <p>143:18, 150:9</p> <p><b>Doctors</b> [2] - 37:13,</p> <p>55:20</p> <p><b>doctors</b> [1] - 81:20</p> <p><b>doctors'</b> [5] - 70:22,</p> <p>76:23, 87:3, 90:23,</p> <p>137:21</p> <p><b>document</b> [3] - 52:7,</p> <p>130:7, 130:11</p> <p><b>documented</b> [2] -</p> <p>53:14, 54:9</p> <p><b>documents</b> [4] -</p> <p>17:12, 17:13, 17:14,</p> <p>115:2</p> <p><b>dollars</b> [15] - 123:5,</p> <p>123:11, 123:12,</p> <p>125:19, 126:3,</p> <p>126:5, 126:9,</p> <p>126:14, 126:17,</p> <p>127:1, 128:1, 128:2,</p> <p>128:15, 134:8,</p> <p>134:15</p> <p><b>dominus</b> [1] - 97:25</p> <p><b>done</b> [18] - 9:22, 30:9,</p>	<p>31:6, 52:3, 55:11,</p> <p>56:14, 56:16, 56:23,</p> <p>56:25, 103:9,</p> <p>109:11, 109:13,</p> <p>135:5, 135:17,</p> <p>135:22, 152:4, 152:5</p> <p><b>dopamine</b> [1] - 64:14</p> <p><b>dope</b> [1] - 140:10</p> <p><b>dosage</b> [1] - 23:21</p> <p><b>doses</b> [2] - 19:6, 19:7</p> <p><b>dots</b> [2] - 65:5, 98:11</p> <p><b>doubled</b> [1] - 13:4</p> <p><b>Douglas</b> [1] - 4:23</p> <p><b>down</b> [11] - 13:4,</p> <p>29:15, 67:5, 91:6,</p> <p>101:4, 140:20,</p> <p>141:4, 148:4,</p> <p>149:15, 151:6, 151:9</p> <p><b>downstream</b> [6] -</p> <p>28:18, 107:8, 121:9,</p> <p>128:10, 135:13,</p> <p>151:3</p> <p><b>dozen</b> [3] - 99:1, 99:9,</p> <p>107:3</p> <p><b>dozens</b> [5] - 130:23,</p> <p>131:5, 131:8</p> <p><b>Dr</b> [145] - 8:17, 13:18,</p> <p>13:19, 13:20, 14:12,</p> <p>14:14, 14:15, 15:9,</p> <p>15:14, 15:18, 15:19,</p> <p>15:20, 16:3, 16:6,</p> <p>16:20, 17:13, 20:25,</p> <p>21:8, 21:16, 21:21,</p> <p>22:3, 22:8, 22:10,</p> <p>22:11, 22:13, 23:25,</p> <p>24:13, 24:15, 24:17,</p> <p>24:19, 25:1, 25:6,</p> <p>25:15, 26:16, 27:20,</p> <p>29:13, 30:6, 30:11,</p> <p>30:15, 31:12, 32:1,</p> <p>32:3, 32:7, 32:24,</p> <p>33:5, 33:9, 34:6,</p> <p>34:11, 34:15, 35:3,</p> <p>35:9, 35:13, 35:17,</p> <p>35:22, 36:8, 36:10,</p> <p>36:14, 38:25, 39:2,</p> <p>39:12, 39:18, 48:20,</p> <p>60:16, 60:21, 62:3,</p> <p>63:13, 63:19, 64:1,</p> <p>64:2, 64:6, 64:11,</p> <p>64:18, 65:4, 66:5,</p> <p>66:16, 66:17, 73:21,</p> <p>74:2, 74:13, 74:24,</p> <p>75:8, 75:18, 76:12,</p> <p>76:19, 77:23, 78:3,</p> <p>78:16, 79:2, 79:21,</p> <p>81:15, 81:22, 82:6,</p> <p>87:11, 88:21, 89:1,</p> <p>96:20, 97:20, 98:15,</p> <p>109:21, 113:8,</p>	<p>113:24, 114:9,</p> <p>115:8, 115:12,</p> <p>119:13, 119:17,</p> <p>119:20, 121:22,</p> <p>123:4, 125:10,</p> <p>125:13, 125:16,</p> <p>125:18, 125:21,</p> <p>126:20, 127:3,</p> <p>127:6, 127:10,</p> <p>127:18, 127:22,</p> <p>127:24, 129:1,</p> <p>129:5, 129:11,</p> <p>130:6, 130:17,</p> <p>130:20, 131:22,</p> <p>132:5, 132:7,</p> <p>132:16, 132:20,</p> <p>132:21, 133:6,</p> <p>140:21, 140:24,</p> <p>142:25</p> <p><b>draft</b> [4] - 15:21,</p> <p>126:2, 126:10,</p> <p>126:11</p> <p><b>dramatically</b> [1] -</p> <p>113:2</p> <p><b>drastically</b> [1] - 37:13</p> <p><b>draw</b> [1] - 149:12</p> <p><b>drive</b> [5] - 10:7, 10:16,</p> <p>10:24, 39:14, 75:5</p> <p><b>Drive</b> [1] - 6:15</p> <p><b>driven</b> [2] - 70:22,</p> <p>114:22</p> <p><b>drives</b> [4] - 10:20,</p> <p>10:21, 75:11, 75:12</p> <p><b>driving</b> [2] - 62:17,</p> <p>139:16</p> <p><b>drop</b> [2] - 114:14,</p> <p>127:25</p> <p><b>drove</b> [5] - 73:20,</p> <p>75:9, 80:21, 83:19,</p> <p>136:10</p> <p><b>Drs</b> [2] - 17:24, 34:4</p> <p><b>drug</b> [54] - 7:23, 44:10,</p> <p>44:23, 52:23, 61:17,</p> <p>61:19, 62:9, 63:25,</p> <p>64:16, 64:18, 65:24,</p> <p>66:1, 66:3, 66:12,</p> <p>67:3, 67:4, 71:24,</p> <p>82:19, 82:20, 98:23,</p> <p>101:22, 112:21,</p> <p>112:23, 114:16,</p> <p>114:17, 114:22,</p> <p>115:4, 115:16,</p> <p>115:22, 116:3,</p> <p>116:13, 116:14,</p> <p>116:21, 117:3,</p> <p>117:7, 117:16,</p> <p>117:21, 117:22,</p> <p>117:25, 118:4,</p> <p>118:7, 118:14,</p> <p>118:17, 118:19,</p>	<p>120:6, 120:7, 120:9,</p> <p>120:14, 128:10,</p> <p>139:22, 142:6</p> <p><b>DRUG</b> [2] - 1:7, 1:13</p> <p><b>Drug</b> [6] - 6:2, 78:4,</p> <p>114:4, 115:13,</p> <p>119:21, 154:5</p> <p><b>drugs</b> [28] - 52:21,</p> <p>61:13, 61:25, 62:7,</p> <p>62:16, 63:1, 63:22,</p> <p>63:23, 63:24, 63:25,</p> <p>64:4, 64:5, 64:7,</p> <p>72:1, 72:4, 78:12,</p> <p>87:16, 114:21,</p> <p>114:22, 116:3,</p> <p>116:4, 116:7,</p> <p>116:16, 119:4,</p> <p>119:10, 119:16,</p> <p>120:14</p> <p><b>due</b> [17] - 40:14,</p> <p>44:18, 49:19, 51:9,</p> <p>51:13, 51:16, 51:18,</p> <p>51:19, 51:21, 52:3,</p> <p>52:4, 53:2, 56:14,</p> <p>56:16, 69:9, 105:14,</p> <p>108:10</p> <p><b>duration</b> [4] - 126:3,</p> <p>127:12, 127:15,</p> <p>127:16</p> <p><b>during</b> [9] - 8:24,</p> <p>11:12, 22:7, 27:22,</p> <p>47:2, 51:23, 54:11,</p> <p>91:11, 127:13</p> <p><b>During</b> [1] - 38:24</p> <p><b>duty</b> [11] - 139:13,</p> <p>139:15, 143:23,</p> <p>143:24, 144:2,</p> <p>144:20, 145:9,</p> <p>145:11, 150:25,</p> <p>151:1</p>
<b>E</b>				
<p><b>early</b> [6] - 15:10,</p> <p>16:22, 29:14, 37:15,</p> <p>42:25, 45:19</p> <p><b>easier</b> [3] - 19:17,</p> <p>21:8, 35:25</p> <p><b>easily</b> [2] - 74:14,</p> <p>139:17</p> <p><b>East</b> [3] - 3:5, 3:12,</p> <p>4:24</p> <p><b>Eastern</b> [1] - 104:6</p> <p><b>easy</b> [1] - 112:14</p> <p><b>echo</b> [1] - 43:23</p> <p><b>economic</b> [2] - 62:13,</p> <p>64:21</p> <p><b>economist</b> [1] - 74:24</p> <p><b>economists</b> [4] - 10:8,</p> <p>10:11, 10:13, 39:1</p>				

<u>education</u> [4] - 21:17, 22:13, 24:24, 74:18	<u>end</u> [7] - 11:3, 16:23, 19:5, 20:4, 33:15, 42:14, 46:5	<u>44:15, 45:11, 47:1, 47:9, 51:25, 52:2, 94:6</u>	<u>95:18, 95:20, 95:22, 95:24, 96:9, 96:10, 96:17, 97:4, 97:12, 98:15, 98:23, 99:4, 99:7, 99:11, 100:2, 100:12, 100:20, 100:25, 101:2, 101:12, 102:11, 102:14, 102:19, 102:20, 103:7, 105:21, 106:17, 106:21, 106:24, 107:2, 109:3, 109:5, 109:12, 109:14, 112:22, 112:24, 113:14, 113:18, 113:20, 117:14, 117:15, 117:20, 117:22, 117:25, 118:3, 118:20, 118:21, 118:23, 119:1, 120:4, 122:3, 123:20, 123:22, 124:6, 124:9, 124:10, 124:14, 125:1, 125:9, 125:10, 128:24, 133:7, 133:11, 134:3, 134:9, 134:16, 135:3, 135:4, 135:20, 136:1, 136:8, 136:17, 137:7, 138:9</u>	<u>108:20</u>
<u>Edward</u> [1] - 89:20	<u>ended</u> [5] - 31:1, 32:20, 111:13, 113:12, 147:19	<u>establish</u> [16] - 63:3, 70:19, 71:10, 72:2, 80:23, 81:4, 83:24, 87:4, 87:5, 120:12, 124:3, 124:15, 136:18, 136:19, 136:20	<u>exception</u> [1] - 68:10	<u>exception</u> [1] - 68:10
<u>effect</u> [4] - 25:22, 62:25, 119:22, 140:10	<u>enemy</u> [1] - 147:10	<u>established</u> [5] - 58:9, 82:8, 109:5, 109:23, 116:20	<u>excessive</u> [10] - 40:24, 41:4, 74:10, 96:8, 99:16, 101:18, 103:4, 111:6, 113:15, 121:11	<u>excessive</u> [10] - 40:24, 41:4, 74:10, 96:8, 99:16, 101:18, 103:4, 111:6, 113:15, 121:11
<u>effective</u> [4] - 18:19, 90:9, 110:18, 139:15	<u>enforcement</u> [3] - 28:10, 40:8, 48:24	<u>establishes</u> [10] - 72:10, 87:7, 103:7, 103:18, 106:24, 107:2, 108:25, 111:7, 113:22, 136:9	<u>Excessive</u> [2] - 41:13, 41:23	<u>Excessive</u> [2] - 41:13, 41:23
<u>effectively</u> [2] - 93:5, 119:19	<u>engage</u> [1] - 115:16	<u>estimating</u> [1] - 118:24	<u>exclamation</u> [1] - 100:17	<u>exclamation</u> [1] - 100:17
<u>effects</u> [2] - 91:13, 135:11	<u>engaged</u> [2] - 7:15, 8:13	<u>estimate</u> [2] - 108:7, 125:18	<u>exclude</u> [1] - 49:13	<u>exclude</u> [1] - 49:13
<u>effort</u> [2] - 44:18, 134:10	<u>Engineers</u> [1] - 149:5	<u>estimated</u> [1] - 127:11	<u>excluded</u> [3] - 96:8, 96:20, 97:13	<u>excluded</u> [3] - 96:8, 96:20, 97:13
<u>efforts</u> [1] - 68:17	<u>English</u> [1] - 151:16	<u>estimates</u> [1] - 135:9	<u>excuse</u> [1] - 13:20	<u>excuse</u> [1] - 13:20
<u>Eighth</u> [1] - 3:10	<u>enhanced</u> [1] - 53:1	<u>et</u> [4] - 1:7, 1:13, 154:4, 154:5	<u>Excuse</u> [1] - 10:10	<u>Excuse</u> [1] - 10:10
<u>either</u> [9] - 39:10, 47:5, 59:3, 61:3, 61:5, 67:3, 86:18, 90:1, 129:8	<u>enhancement</u> [1] - 44:4	<u>evaluate</u> [7] - 8:19, 17:17, 26:8, 45:8, 50:7, 108:2, 129:24	<u>exercise</u> [2] - 129:23, 134:23	<u>exercise</u> [2] - 129:23, 134:23
<u>Either</u> [1] - 61:2	<u>enormous</u> [2] - 62:9, 114:12	<u>evaluated</u> [3] - 45:1, 84:17, 84:18	<u>exercising</u> [1] - 58:8	<u>exercising</u> [1] - 58:8
<u>elaborate</u> [1] - 131:14	<u>ensure</u> [2] - 16:14, 28:11	<u>evaluating</u> [5] - 36:23, 97:3, 129:14, 131:23, 132:8	<u>existed</u> [1] - 55:19	<u>existed</u> [1] - 55:19
<u>electronic</u> [2] - 44:22, 47:13	<u>entered</u> [3] - 58:15, 58:24, 105:3	<u>evaluation</u> [3] - 44:18, 135:5, 135:6	<u>existence</u> [3] - 56:12, 72:9, 72:12	<u>existence</u> [3] - 56:12, 72:9, 72:12
<u>element</u> [1] - 121:2	<u>entire</u> [17] - 8:24, 13:3, 37:25, 47:20, 52:20, 57:16, 69:12, 73:9, 94:11, 97:12, 98:5, 120:20, 130:16, 132:14, 137:20, 139:22, 142:15	<u>event</u> [2] - 23:20, 149:22	<u>existing</u> [1] - 44:19	<u>existing</u> [1] - 44:19
<u>elements</u> [3] - 84:11, 84:17, 117:10	<u>entirely</u> [9] - 15:15, 62:4, 72:6, 95:10, 96:15, 97:13, 113:15, 115:20, 128:7	<u>events</u> [4] - 52:21, 67:8, 67:15, 81:19	<u>exists</u> [2] - 83:10, 123:23	<u>exists</u> [2] - 83:10, 123:23
<u>eligible</u> [1] - 125:3	<u>entirety</u> [3] - 51:16, 54:11, 135:10	<u>evidence</u> [134] - 9:2, 9:8, 9:11, 10:25, 11:15, 11:23, 12:18, 12:19, 24:12, 29:10, 29:24, 31:3, 31:4, 31:15, 32:13, 33:17, 33:23, 36:10, 47:1, 47:23, 48:3, 48:10, 53:19, 53:25, 54:22, 56:5, 56:19, 58:23, 63:5, 65:12, 65:13, 65:20, 67:18, 68:16, 70:15, 71:17, 72:5, 72:21, 73:18, 75:20, 76:6, 76:25, 77:15, 77:20, 78:3, 79:11, 79:12, 80:20, 80:22, 83:6, 83:21, 87:2, 87:7, 87:17, 89:13, 90:12, 90:24, 95:15,	<u>expanded</u> [1] - 87:18	<u>expanded</u> [1] - 87:18
<u>eliminate</u> [1] - 17:3	<u>entitled</u> [3] - 122:19, 128:9, 135:13		<u>expanding</u> [1] - 83:22	<u>expanding</u> [1] - 83:22
<u>ELIZABETH</u> [1] - 6:14	<u>entrust</u> [1] - 152:5		<u>expansion</u> [2] - 74:4, 76:20	<u>expansion</u> [2] - 74:4, 76:20
<u>elsewhere</u> [1] - 117:17	<u>ENU</u> [1] - 4:17		<u>expect</u> [7] - 35:15, 37:1, 60:10, 77:4, 123:9, 135:21, 146:20	<u>expect</u> [7] - 35:15, 37:1, 60:10, 77:4, 123:9, 135:21, 146:20
<u>email</u> [11] - 43:6, 43:7, 43:9, 43:12, 53:5, 53:8, 53:11, 53:12, 53:15, 60:17	<u>epicenter</u> [1] - 130:5		<u>expectations</u> [5] - 36:21, 41:8, 42:12, 42:15, 47:15	<u>expectations</u> [5] - 36:21, 41:8, 42:12, 42:15, 47:15
<u>embraced</u> [3] - 17:6, 45:11, 45:12	<u>epidemic</u> [7] - 7:12, 18:12, 58:6, 64:23, 65:22, 72:9, 73:23		<u>expected</u> [3] - 37:6, 89:1, 117:16	<u>expected</u> [3] - 37:6, 89:1, 117:16
<u>emphasis</u> [3] - 84:1, 84:19, 110:14	<u>epidemiologist</u> [1] - 25:6		<u>experience</u> [6] - 27:10, 40:25, 41:24, 42:1, 64:8, 129:14	<u>experience</u> [6] - 27:10, 40:25, 41:24, 42:1, 64:8, 129:14
<u>emphasize</u> [2] - 103:11, 120:8	<u>equal</u> [1] - 9:6		<u>experienced</u> [2] - 7:12, 73:25	<u>experienced</u> [2] - 7:12, 73:25
<u>emphasized</u> [1] - 115:4	<u>equally</u> [3] - 51:6, 58:10, 58:21		<u>expert</u> [9] - 8:9, 35:11, 36:25, 64:18, 71:5, 127:3, 129:4, 129:13, 146:19	<u>expert</u> [9] - 8:9, 35:11, 36:25, 64:18, 71:5, 127:3, 129:4, 129:13, 146:19
<u>employees</u> [1] - 8:7	<u>equitable</u> [3] - 67:25, 134:24, 135:3		<u>expertise</u> [2] - 27:6, 46:17	<u>expertise</u> [2] - 27:6, 46:17
<u>Employer</u> [10] - 81:1, 81:18, 82:9, 82:23, 84:20, 86:13, 86:19, 86:24, 136:19, 137:2	<u>equity</u> [2] - 67:25, 134:23		<u>experts</u> [6] - 8:11, 15:17, 75:13, 96:19, 129:3, 136:14	<u>experts</u> [6] - 8:11, 15:17, 75:13, 96:19, 129:3, 136:14
<u>empty</u> [1] - 129:22	<u>era</u> [1] - 139:25		<u>explain</u> [6] - 29:8, 32:23, 53:6, 76:20, 119:24, 130:12	<u>explain</u> [6] - 29:8, 32:23, 53:6, 76:20, 119:24, 130:12
<u>Encino</u> [1] - 3:16	<u>eras</u> [1] - 40:3		<u>explained</u> [6] - 16:20, 21:16, 29:7, 35:22, 63:13, 96:19	<u>explained</u> [6] - 16:20, 21:16, 29:7, 35:22, 63:13, 96:19
<u>encompass</u> [1] - 61:24	<u>error</u> [1] - 108:4		<u>explains</u> [1] - 43:17	<u>explains</u> [1] - 43:17
<u>encourage</u> [3] - 15:23, 16:10, 20:6	<u>essentially</u> [11] - 8:21, 21:24, 24:2, 43:23,		<u>explanation</u> [4] - 35:2,	<u>explanation</u> [4] - 35:2,
<u>encouraged</u> [6] - 19:13, 20:9, 89:7, 118:4, 118:9, 137:25				
<u>encouragement</u> [1] - 88:18				
<u>encouraging</u> [2] -				



<p>75:22, 125:2, 131:19  <u>explicit</u> [1] - 88:17  <u>explicitly</u> [1] - 81:22  <u>expose</u> [1] - 20:13  <u>exposed</u> [3] - 122:15,  122:18, 122:21  <u>exposes</u> [1] - 95:17  <u>exposure</u> [1] - 79:3  <u>express</u> [1] - 20:22  <u>expressing</u> [1] - 138:8  <u>expressly</u> [1] - 41:16  <u>extend</u> [1] - 94:24  <u>extensive</u> [1] - 83:21,  88:13, 115:7,  116:13, 129:14,  130:23, 130:25,  131:5, 131:8, 131:14  <u>extensively</u> [1] - 89:12  <u>extent</u> [4] - 9:4, 32:20,  46:2, 54:20  <u>extremely</u> [2] - 69:18,  88:19</p>	<p>143:16  <u>factual</u> [2] - 92:11,  93:2  <u>fail</u> [1] - 10:25  <u>failed</u> [7] - 58:11, 69:4,  69:6, 72:11, 127:11,  134:20, 149:17  <u>fails</u> [1] - 118:14  <u>failure</u> [12] - 11:14,  48:11, 69:9, 69:15,  102:17, 102:22,  105:10, 105:13,  106:8, 120:10,  125:11, 128:19  <u>failures</u> [3] - 106:22,  111:4, 134:25  <u>fairly</u> [1] - 122:10  <u>fairness</u> [1] - 112:10  <u>faith</u> [2] - 9:12, 31:7,  31:24, 32:3, 32:5,  37:16, 70:23, 71:12,  76:7, 76:14, 77:2,  78:20, 90:14, 90:17,  91:8, 95:3, 117:21,  137:9, 137:21,  152:1, 152:2  <u>fallen</u> [1] - 113:4  <u>falling</u> [1] - 24:8  <u>false</u> [1] - 8:14  <u>familiar</u> [2] - 31:11,  46:19  <u>family</u> [4] - 44:24,  52:24, 77:21, 82:19  <u>famous</u> [1] - 9:24  <u>fancy</u> [1] - 149:5  <u>far</u> [15] - 26:2, 31:16,  32:23, 33:1, 34:13,  37:14, 47:2, 49:14,  63:2, 83:17, 112:12,  113:20, 116:16  <u>Farley</u> [4] - 85:16,  85:18, 85:21, 85:22  <u>FARRELL</u> [15] - 2:3,  138:18, 138:20,  138:23, 139:1,  140:15, 142:9,  142:21, 142:24,  143:10, 146:15,  146:22, 147:2,  147:24, 148:9  <u>Farrell</u> [15] - 2:4, 2:13,  16:4, 53:10, 66:6,  73:10, 88:1, 92:6,  113:3, 120:25,  138:16, 146:21,  147:23, 148:8, 152:9  <u>Farrell's</u> [3] - 72:18,  73:6, 113:6  <u>fast</u> [1] - 18:1  <u>fault</u> [1] - 48:3</p>	<p><u>FCRR</u> [1] - 6:18  <u>FDA</u> [13] - 12:12, 27:9,  62:25, 66:23, 87:7,  87:13, 87:14, 87:20,  87:25, 89:5, 116:17,  117:25, 137:24  <u>fear</u> [2] - 19:4, 21:11  <u>featured</u> [1] - 62:2  <u>Federal</u> [3] - 31:17,  67:24, 149:25  <u>federal</u> [7] - 12:8,  12:10, 68:22, 103:3,  103:4, 110:17,  127:14  <u>federally</u> [2] - 60:2,  60:4  <u>Feinberg</u> [2] - 64:18,  127:3  <u>Feinberg's</u> [1] - 127:6  <u>fell</u> [3] - 16:11, 24:9  <u>felt</u> [1] - 20:15  <u>fentanyl</u> [20] - 58:17,  61:15, 61:16, 62:6,  62:21, 62:24, 67:3,  71:25, 72:4, 113:25,  114:1, 114:8,  114:12, 115:8,  116:15, 117:19,  118:11  <u>fentanyl-laced</u> [1] -  62:6  <u>few</u> [5] - 19:21, 21:19,  42:13, 63:6, 99:22  <u>fewer</u> [4] - 16:12,  29:23, 104:19, 105:1  <u>Field</u> [2] - 106:11,  106:14  <u>fifth</u> [1] - 16:25,  17:16, 17:25, 18:11,  24:17, 25:20, 59:22,  60:23, 72:5, 83:5,  83:20  <u>fight</u> [1] - 130:12  <u>figure</u> [3] - 50:1, 63:8,  135:21  <u>file</u> [9] - 52:4, 52:11,  53:3, 53:14, 53:18,  53:24, 104:8,  152:22, 153:1  <u>filed</u> [5] - 29:19, 55:13,  68:5, 78:10, 128:21  <u>files</u> [5] - 47:22, 51:16,  109:8, 109:10  <u>fill</u> [4] - 12:8, 16:15,  60:10, 62:18  <u>filled</u> [4] - 38:11, 52:9,  55:18, 56:8  <u>filling</u> [2] - 31:1, 67:6  <u>final</u> [6] - 36:17, 43:11,  64:13, 147:5, 153:1</p>	<p><u>finally</u> [2] - 61:6,  133:16  <u>financial</u> [1] - 68:19  <u>findings</u> [5] - 47:7,  47:25, 152:10,  153:4, 153:6  <u>fine</u> [1] - 130:15  <u>fingers</u> [1] - 73:1  <u>finished</u> [1] - 138:20  <u>Firm</u> [2] - 3:4, 3:7  <u>firms</u> [3] - 132:1,  132:4, 135:8  <u>first</u> [27] - 24:6, 25:1,  30:2, 42:13, 44:10,  62:22, 70:19, 70:20,  73:18, 77:15, 79:25,  85:12, 92:3, 93:20,  102:24, 104:15,  105:6, 106:24,  108:16, 108:19,  114:18, 119:14,  124:6, 125:12,  126:2, 136:25,  139:11  <u>First</u> [2] - 19:13, 60:2  <u>fish</u> [1] - 147:21  <u>Fishman</u> [2] - 21:21,  22:11  <u>Fishman's</u> [2] - 22:3,  22:8  <u>fit</u> [2] - 36:20, 92:16  <u>fits</u> [2] - 51:3, 82:7  <u>five</u> [4] - 29:24, 63:11,  70:16, 97:22  <u>FL</u> [1] - 2:11  <u>flagged</u> [10] - 49:20,  49:21, 49:24, 50:8,  50:25, 107:16,  108:1, 108:3,  108:19, 109:17  <u>flagging</u> [5] - 9:25,  50:21, 107:17,  108:13, 109:15  <u>Flaherty</u> [1] - 5:14  <u>FLAHIVE</u> [1] - 5:10  <u>flaw</u> [6] - 121:19,  122:16, 122:23,  128:13, 130:17,  132:21  <u>flawed</u> [3] - 72:7,  135:6, 135:8  <u>flaws</u> [5] - 114:16,  120:18, 125:7,  125:8, 132:13  <u>flood</u> [2] - 117:17,  150:23  <u>flooding</u> [1] - 150:5  <u>Floor</u> [1] - 3:5  <u>floor</u> [1] - 141:23  <u>Florida</u> [4] - 48:19,</p>	<p>49:2, 49:3, 98:23  <u>flowing</u> [1] - 118:13  <u>focus</u> [6] - 20:22,  20:23, 36:3, 46:12,  46:16, 48:5  <u>focused</u> [7] - 9:4,  29:5, 57:14, 66:3,  66:8, 66:17, 113:15  <u>focuses</u> [1] - 66:12  <u>fold</u> [2] - 33:10, 33:12  <u>folks</u> [1] - 40:22  <u>follow</u> [4] - 57:25,  58:1, 88:23, 94:15  <u>follow-up</u> [2] - 57:25,  58:1  <u>followed</u> [4] - 23:24,  42:11, 53:13, 68:3  <u>following</u> [2] - 22:18,  69:13  <u>follows</u> [4] - 7:5,  41:22, 70:16, 90:15  <u>fond</u> [1] - 151:8  <u>FOR</u> [1] - 1:1  <u>force</u> [2] - 62:17,  90:22  <u>foreclosed</u> [1] - 70:14  <u>forecloses</u> [2] - 72:13,  89:15  <u>foregoing</u> [1] - 154:2  <u>foresaw</u> [4] - 117:21,  117:22, 117:25,  118:4  <u>foreseeability</u> [9] -  26:25, 57:14, 84:8,  84:10, 84:14, 84:16,  117:10, 117:13  <u>foreseeable</u> [3] -  117:6, 117:14, 118:7  <u>foreseen</u> [1] - 117:15  <u>fork</u> [1] - 148:6  <u>form</u> [3] - 59:2, 72:18,  144:23  <u>former</u> [5] - 8:7, 24:16,  40:7, 45:4, 45:5  <u>formulation</u> [4] -  89:21, 90:1, 103:15,  137:13  <u>forth</u> [1] - 94:14  <u>forward</u> [11] - 7:7,  18:2, 41:19, 42:24,  43:1, 99:10, 106:21,  106:23, 113:7,  114:13, 135:22  <u>forward-looking</u> [3] -  99:10, 106:21,  106:23  <u>foundation</u> [1] - 74:4  <u>four</u> [10] - 49:1, 49:2,  49:5, 49:6, 50:19,  63:11, 107:25,</p>
--	--	--	--	---

<p>130:21, 152:3  <b>fourth</b> [3] - 33:23,  65:1, 71:24  <b>fraction</b> [1] - 67:2  <b>frame</b> [1] - 73:17  <b>framework</b> [5] - 86:14,  135:23, 136:20,  136:22, 142:23  <b>frameworks</b> [1] -  112:18  <b>freely</b> [1] - 19:14  <b>French</b> [1] - 39:9  <b>frequency</b> [3] -  103:16, 103:20,  103:22  <b>friends</b> [2] - 77:21,  82:19  <b>frightened</b> [1] -  115:16  <b>fueling</b> [2] - 73:22,  140:12  <b>full</b> [9] - 45:20, 53:13,  53:21, 53:24, 58:11,  84:3, 92:2, 129:21,  136:24  <b>Fuller</b> [2] - 2:4, 2:13  <b>FULLER</b> [1] - 2:12  <b>fully</b> [3] - 28:7, 57:12,  103:1  <b>fund</b> [13] - 124:4,  124:5, 124:10,  124:15, 124:16,  124:19, 124:21,  124:25, 125:2,  125:3, 125:5, 125:7,  134:15  <b>fundamental</b> [6] -  73:2, 95:17, 114:16,  115:21, 128:17,  132:21  <b>fundamentally</b> [3] -  113:21, 121:7,  124:18  <b>funded</b> [5] - 123:8,  130:13, 132:1,  132:4, 135:7  <b>funding</b> [15] - 68:21,  68:22, 123:18,  123:21, 123:23,  123:24, 124:11,  124:12, 124:17,  125:23, 126:6,  131:22, 131:23,  134:3, 134:19  <b>funds</b> [8] - 124:7,  125:5, 133:12,  133:13, 133:18,  134:7, 134:10,  134:14  <b>furtherance</b> [1] - 44:1</p>	<p><b>furthermore</b> [3] -  76:19, 109:16, 134:7  <b>future</b> [9] - 43:21,  60:11, 121:20,  121:21, 122:1,  122:3, 122:4, 122:5,  123:22</p> <p style="text-align: center;"><b>G</b></p> <p><b>gap</b> [5] - 77:15, 77:16,  77:17, 95:17, 112:22  <b>gateway</b> [15] - 62:19,  62:22, 62:25, 63:4,  63:6, 64:16, 65:1,  65:11, 118:18,  118:21, 119:11,  120:2, 120:5, 120:9,  120:15  <b>Gateway</b> [1] - 62:23  <b>gauge</b> [1] - 148:15  <b>Gauley</b> [2] - 148:24,  148:25  <b>general</b> [2] - 25:4,  85:19  <b>General</b> [2] - 20:21,  106:7  <b>generally</b> [2] - 61:24,  109:7  <b>generation</b> [1] - 42:18  <b>generic</b> [1] - 49:14  <b>gestalt</b> [1] - 25:4  <b>Gilligan</b> [12] - 15:9,  15:19, 16:20, 17:24,  24:13, 26:16, 63:13,  63:19, 64:2, 87:12,  113:24, 119:17  <b>given</b> [15] - 11:13,  28:15, 37:10, 38:5,  69:19, 69:20, 80:11,  80:19, 80:21, 87:2,  89:10, 89:13,  111:13, 115:25,  136:17  <b>glaring</b> [1] - 67:19  <b>goalpost</b> [1] - 136:20  <b>government</b> [4] - 12:8,  12:10, 123:10,  127:14  <b>governmental</b> [1] -  68:8  <b>governments</b> [2] -  68:11, 140:1  <b>grade</b> [1] - 116:10  <b>grant</b> [1] - 123:17  <b>grappling</b> [1] - 99:19  <b>grateful</b> [2] - 69:18,  138:12  <b>great</b> [3] - 13:9, 19:19,  139:4</p>	<p><b>greater</b> [4] - 15:23,  16:10, 88:10, 88:12  <b>Greek</b> [3] - 151:15,  151:16, 151:18  <b>GRETCHEN</b> [1] - 6:7  <b>grew</b> [1] - 38:1  <b>grossly</b> [1] - 132:12  <b>ground</b> [1] - 10:14  <b>grounds</b> [2] - 57:10,  118:15  <b>grow</b> [1] - 139:24  <b>guess</b> [6] - 14:24,  71:13, 77:1, 77:5,  90:23, 137:16  <b>guessed</b> [1] - 9:23  <b>guessing</b> [1] - 95:12  <b>guidance</b> [7] - 42:19,  46:10, 47:10, 89:2,  103:24, 104:19,  105:17  <b>guide</b> [2] - 130:11,  135:20  <b>guidelines</b> [7] - 15:21,  23:21, 24:1, 24:2,  66:10, 88:23  <b>guiding</b> [1] - 80:25  <b>gulp</b> [1] - 94:11  <b>Gupta</b> [14] - 24:19,  34:4, 34:6, 34:15,  66:6, 73:21, 74:13,  78:16, 79:21, 88:22,  89:1, 109:21, 113:9,  115:9  <b>Gupta's</b> [5] - 34:11,  62:3, 66:16, 66:17,  81:16</p> <p style="text-align: center;"><b>H</b></p> <p><b>habits</b> [1] - 27:16  <b>half</b> [3] - 54:5, 101:6,  141:11  <b>ham</b> [3] - 91:11, 91:14,  94:19  <b>hand</b> [5] - 14:5, 96:23,  108:21, 141:5,  142:18  <b>handed</b> [2] - 17:12,  21:23  <b>handguns</b> [1] - 94:4  <b>handled</b> [1] - 112:19  <b>handling</b> [1] - 45:24  <b>hands</b> [2] - 67:1,  152:6  <b>hanging</b> [1] - 148:1  <b>happy</b> [1] - 70:3  <b>harbor</b> [1] - 150:9  <b>hard</b> [1] - 153:18  <b>HARDIN</b> [1] - 5:3  <b>harm</b> [29] - 7:16, 8:16,  11:7, 57:5, 70:25,  71:16, 72:17, 80:23,  81:5, 81:24, 82:16,  85:3, 95:25, 96:10,  99:16, 101:14,  102:10, 107:5,  108:3, 109:25,  110:2, 110:4, 110:5,  111:4, 111:7,  111:10, 111:13,  111:18, 136:11  <b>harmful</b> [1] - 71:19  <b>harmful</b> [1] - 94:9  <b>harming</b> [1] - 109:19  <b>harms</b> [22] - 7:23,  11:4, 55:1, 55:7,  72:3, 76:21, 77:18,  78:14, 92:18, 99:12,  102:20, 117:14,  118:13, 120:21,  120:24, 121:9,  121:15, 121:16,  122:20, 128:10,  135:14, 137:21  <b>Harrison</b> [2] - 140:18,  143:2  <b>Harvard</b> [1] - 15:19  <b>Hawkins</b> [1] - 3:7  <b>head</b> [1] - 28:10  <b>health</b> [13] - 18:14,  34:20, 36:5, 37:21,  66:14, 90:25, 91:2,  91:13, 91:15,  123:16, 123:17,  123:18, 123:21  <b>Health</b> [40] - 4:16, 5:2,  7:24, 8:5, 8:7, 8:10,  12:6, 24:16, 24:19,  28:16, 28:17, 28:18,  29:4, 36:19, 40:2,  40:10, 43:4, 44:12,  44:16, 44:20, 46:14,  47:23, 49:24, 51:12,  51:19, 53:12, 54:22,  55:11, 55:19, 56:6,  58:14, 58:23, 59:3,  61:7, 61:17, 62:24,  67:5, 69:11, 144:7,  144:15  <b>Health's</b> [11] - 7:19,  8:2, 8:8, 11:4, 11:16,  37:9, 41:17, 47:3,  52:13, 54:3, 55:8  <b>healthcare</b> [5] - 10:23,  36:14, 36:15, 89:6,  118:8  <b>healthy</b> [1] - 125:16  <b>hear</b> [2] - 148:19  <b>heard</b> [39] - 7:18, 8:20,  15:7, 15:9, 17:22,  22:7, 35:17, 35:19,  36:3, 36:10, 40:3,  42:13, 42:22, 42:25,  44:2, 45:24, 47:2,  54:2, 62:8, 63:5,  63:7, 67:18, 68:16,  68:19, 68:22, 73:5,  73:13, 76:8, 76:25,  83:5, 83:21, 88:9,  88:13, 123:15,  130:1, 141:11,  141:19, 151:10,  151:15  <b>heart</b> [4] - 78:13,  101:18, 147:9, 152:4  <b>height</b> [1] - 148:15  <b>held</b> [5] - 44:25, 45:1,  85:13, 85:23, 122:20  <b>help</b> [1] - 60:23  <b>helped</b> [3] - 18:13,  20:1, 44:10  <b>helps</b> [1] - 36:12  <b>heroin</b> [43] - 58:17,  61:15, 61:16, 62:6,  62:21, 62:24, 63:12,  63:18, 63:21, 64:4,  67:3, 71:25, 72:4,  113:25, 114:1,  114:4, 114:7,  114:11, 115:8,  115:9, 115:10,  115:11, 115:13,  115:14, 116:10,  116:12, 116:15,  117:18, 118:11,  118:22, 118:25,  119:2, 119:6, 119:9,  119:12, 119:13,  119:23, 119:25,  120:1, 120:3,  121:24, 122:1  <b>heroin-fentanyl</b> [1] -  118:11  <b>HESTER</b> [18] - 5:9,  70:1, 70:9, 70:12,  70:14, 86:19, 86:22,  87:2, 92:24, 93:12,  96:15, 97:11,  111:23, 112:2,  138:15, 152:14,  152:24, 153:2  <b>Hester</b> [6] - 62:11,  67:20, 69:24, 70:11,  111:22, 112:1  <b>high</b> [8] - 29:22,  34:24, 37:23, 65:9,  74:2, 98:5, 117:17,  139:8  <b>higher</b> [18] - 32:21,  32:22, 33:15, 33:18,</p>
---	---	--

<p>33:21, 33:25, 34:1, 34:13, 34:16, 34:19, 35:14, 35:15, 36:2, 36:6, 37:18, 37:19, 65:10 <b>highest</b> [3] - 36:6, 73:25, 139:12 <b>highlight</b> [4] - 76:8, 81:12, 96:18, 111:10 <b>highlighted</b> [7] - 81:9, 82:10, 87:9, 113:3, 121:1, 141:7, 141:19 <b>highlighting</b> [2] - 88:15, 128:14 <b>highly</b> [2] - 108:13, 113:12 <b>hill</b> [2] - 74:7 <b>himself</b> [1] - 10:6 <b>hindsight</b> [1] - 77:9 <b>hired</b> [1] - 44:2 <b>historian</b> [1] - 151:7 <b>history</b> [2] - 53:9, 86:18 <b>hit</b> [1] - 51:20 <b>hits</b> [1] - 52:12 <b>hold</b> [4] - 73:8, 83:9, 98:5, 120:5 <b>holding</b> [2] - 61:18, 85:15 <b>holdings</b> [1] - 86:12 <b>holds</b> [1] - 151:12 <b>hole</b> [4] - 53:5, 53:11, 53:15, 62:18 <b>holes</b> [1] - 147:12 <b>home</b> [1] - 97:8 <b>Homer</b> [6] - 131:11, 131:12, 131:21, 131:25, 132:5, 132:11 <b>homes</b> [3] - 71:2, 78:12, 78:23 <b>Honor</b> [146] - 7:8, 7:9, 7:13, 7:21, 8:9, 9:5, 10:2, 10:10, 10:18, 10:22, 11:18, 11:22, 12:1, 12:6, 12:11, 12:23, 13:4, 13:12, 13:23, 14:3, 14:8, 14:11, 14:21, 14:25, 16:2, 16:4, 16:18, 17:11, 19:8, 19:16, 21:20, 22:7, 22:22, 24:11, 25:22, 25:24, 26:4, 26:5, 26:23, 27:19, 27:25, 28:15, 29:1, 29:11, 30:3, 31:5, 31:16, 31:22, 32:13, 32:21, 32:24, 33:18, 33:24, 36:18, 37:12, 38:4, 38:8,</p>	<p>38:15, 38:19, 38:23, 39:6, 39:11, 39:19, 41:5, 42:13, 43:6, 44:2, 44:6, 45:13, 46:20, 46:25, 47:8, 47:25, 48:9, 48:14, 48:25, 49:6, 49:13, 50:2, 50:11, 51:12, 51:17, 52:4, 52:13, 53:18, 53:22, 54:16, 54:19, 54:24, 55:2, 55:10, 56:5, 56:21, 57:7, 57:12, 57:22, 58:9, 58:21, 59:24, 60:8, 62:4, 62:22, 63:7, 63:8, 65:13, 65:20, 66:19, 67:20, 67:24, 68:3, 68:6, 68:13, 68:15, 69:16, 69:19, 70:2, 70:9, 70:12, 72:8, 77:9, 86:20, 92:24, 93:12, 94:1, 96:16, 97:2, 97:11, 101:9, 102:16, 106:20, 110:23, 111:19, 111:23, 112:3, 120:16, 124:18, 129:12, 132:18, 138:15, 144:21, 152:12, 152:13, 152:14, 153:2, 153:21 <b>HONORABLE</b> [1] - 1:17 <b>Honorable</b> [1] - 7:1 <b>hope</b> [1] - 146:23 <b>Hopkins</b> [1] - 17:8 <b>horse</b> [1] - 115:1 <b>Hospice</b> [1] - 100:23 <b>Hospital</b> [1] - 96:5 <b>hospital</b> [4] - 17:2, 18:6, 96:25, 97:7 <b>hospitals</b> [4] - 17:20, 17:23, 28:13, 36:15 <b>hour</b> [1] - 54:6 <b>hours</b> [1] - 139:1 <b>hub</b> [1] - 36:14 <b>huge</b> [4] - 50:20, 114:14, 121:19, 126:19 <b>Hughes</b> [2] - 35:17, 35:22 <b>human</b> [2] - 151:21, 151:24 <b>hundreds</b> [1] - 52:7 <b>Huntington</b> [110] - 3:10, 4:1, 7:12, 7:17, 8:18, 9:1, 11:5, 11:20, 12:16, 12:19,</p>	<p>15:4, 18:2, 18:10, 29:9, 29:22, 30:1, 31:4, 31:6, 32:6, 32:10, 32:12, 32:14, 32:16, 32:18, 32:20, 33:2, 33:6, 33:15, 33:21, 33:25, 36:2, 36:3, 36:5, 36:12, 36:14, 36:18, 36:20, 37:5, 37:10, 38:7, 48:12, 48:23, 51:8, 51:24, 55:12, 55:19, 58:16, 61:14, 62:5, 62:9, 62:16, 67:5, 70:22, 71:16, 71:18, 71:25, 73:5, 73:9, 73:20, 76:15, 76:17, 95:16, 95:19, 95:21, 95:23, 95:25, 96:3, 96:5, 97:17, 97:19, 97:22, 98:1, 98:4, 98:8, 98:13, 98:16, 98:17, 98:20, 98:21, 99:6, 99:8, 99:13, 99:14, 99:23, 99:25, 100:1, 100:7, 100:10, 100:14, 100:21, 101:4, 101:8, 102:2, 102:5, 102:13, 102:20, 106:2, 114:11, 115:1, 115:2, 123:25, 129:10, 132:3, 139:3, 144:3, 146:14, 148:22, 149:6, 150:18, 154:4 <b>HUNTINGTON</b> [1] - 1:4 <b>Huntington's</b> [2] - 68:17, 130:12 <b>Huntington-Cabell</b> [5] - 99:8, 144:3, 148:22, 149:6, 150:18 <b>Huntington/Cabell</b> [1] - 36:13 <b>hurting</b> [1] - 26:3 <b>hydrocodone</b> [4] - 16:8, 145:16, 145:17, 145:20  <b>I</b> <b>idea</b> [9] - 17:6, 26:24, 49:23, 50:5, 61:18, 62:19, 91:5, 112:5, 124:19 <b>identified</b> [4] - 41:1, 45:23, 87:15, 98:18 <b>identify</b> [5] - 8:25,</p>	<p>40:24, 98:19, 100:8, 107:22 <b>ignored</b> [1] - 11:1 <b>ignores</b> [1] - 139:21 <b>illegal</b> [48] - 61:13, 61:25, 62:9, 62:16, 62:20, 63:1, 63:9, 63:23, 63:24, 63:25, 65:3, 65:10, 66:3, 72:1, 72:4, 82:20, 112:21, 112:23, 114:16, 114:17, 114:20, 114:22, 115:7, 115:22, 116:3, 116:4, 116:7, 116:14, 116:16, 116:21, 117:3, 117:7, 117:16, 117:21, 117:22, 117:25, 118:4, 118:7, 118:14, 118:17, 118:19, 119:10, 120:6, 120:9, 120:13, 120:14, 140:11 <b>illegally</b> [5] - 60:6, 61:6, 63:16, 101:22, 142:6 <b>illicit</b> [8] - 61:16, 71:25, 72:4, 80:15, 114:11, 115:8, 115:16, 117:18 <b>illicitly</b> [1] - 80:16 <b>illustrated</b> [1] - 114:10 <b>imagine</b> [3] - 62:11, 70:2, 93:1 <b>immediate</b> [2] - 145:21 <b>immediately</b> [2] - 53:12, 105:6 <b>immunity</b> [1] - 141:15 <b>immunize</b> [1] - 150:9 <b>impact</b> [1] - 26:11 <b>impeaches</b> [1] - 126:17 <b>imperatively</b> [2] - 89:19, 137:11 <b>implement</b> [1] - 143:11 <b>implementing</b> [1] - 44:13 <b>implication</b> [2] - 90:19, 95:5 <b>implications</b> [1] - 90:21 <b>importance</b> [1] - 88:11 <b>important</b> [20] - 21:22, 23:7, 27:17, 44:5, 70:6, 71:12, 83:21, 87:13, 87:21, 88:19,</p>	<p>90:6, 90:10, 94:22, 99:8, 103:10, 105:11, 106:20, 107:20, 131:22, 146:20 <b>impose</b> [2] - 134:21, 135:23 <b>imposes</b> [1] - 59:2 <b>imprecise</b> [1] - 61:23 <b>imprecision</b> [1] - 108:6 <b>improper</b> [4] - 8:15, 71:17, 95:20, 95:23 <b>improvements</b> [1] - 46:9 <b>IN</b> [2] - 1:1, 1:18 <b>inadequate</b> [1] - 123:23 <b>inappropriate</b> [2] - 20:12, 103:4 <b>include</b> [1] - 96:25 <b>included</b> [4] - 45:2, 47:18, 122:1, 122:19 <b>includes</b> [2] - 52:18, 122:15 <b>including</b> [13] - 18:15, 26:9, 29:18, 35:18, 58:7, 67:15, 68:21, 69:13, 81:19, 82:11, 82:14, 117:1, 119:25 <b>incompatible</b> [1] - 108:7 <b>increase</b> [9] - 9:9, 32:17, 32:19, 33:10, 74:6, 78:12, 87:23, 115:8, 140:11 <b>increased</b> [11] - 9:14, 15:14, 21:17, 22:14, 28:13, 33:12, 70:21, 115:10, 115:11, 118:9, 136:10 <b>increases</b> [3] - 9:16, 28:8, 28:9 <b>increasing</b> [6] - 10:15, 28:16, 28:24, 29:2, 59:22, 117:23 <b>increasingly</b> [2] - 15:11, 78:7 <b>independent</b> [4] - 81:20, 83:13, 85:1 <b>independently</b> [3] - 85:19, 85:25, 86:5 <b>indictment</b> [3] - 140:22, 140:24, 140:25 <b>individual</b> [4] - 63:1, 93:10, 126:21, 139:9 <b>individuals</b> [2] - 92:14, 140:22 <b>Industries</b> [1] - 93:18</p>
--	--	--	---	---

<p><b>industry</b> <sup>[11]</sup> - 39:5, 39:13, 41:24, 42:20, 42:23, 43:19, 75:6, 103:24, 140:18</p> <p><b>inept</b> <sup>[11]</sup> - 93:15</p> <p><b>inevitable</b> <sup>[11]</sup> - 26:18</p> <p><b>infant</b> <sup>[11]</sup> - 143:3</p> <p><b>infers</b> <sup>[11]</sup> - 142:13</p> <p><b>inflated</b> <sup>[11]</sup> - 126:22</p> <p><b>influence</b> <sup>[11]</sup> - 74:18</p> <p><b>influential</b> <sup>[11]</sup> - 17:5</p> <p><b>influx</b> <sup>[11]</sup> - 66:1</p> <p><b>inform</b> <sup>[11]</sup> - 29:25</p> <p><b>information</b> <sup>[9]</sup> - 15:15, 27:5, 30:13, 31:25, 45:13, 52:14, 52:15, 52:17, 54:21</p> <p><b>informed</b> <sup>[11]</sup> - 32:14</p> <p><b>Ingredient</b> <sup>[3]</sup> - 40:16, 41:12</p> <p><b>inherent</b> <sup>[11]</sup> - 94:16</p> <p><b>inherently</b> <sup>[2]</sup> - 13:7, 14:7</p> <p><b>initial</b> <sup>[11]</sup> - 49:21</p> <p><b>initiate</b> <sup>[2]</sup> - 17:18, 43:20</p> <p><b>injured</b> <sup>[4]</sup> - 60:14, 91:1, 92:14, 93:22</p> <p><b>injuries</b> <sup>[2]</sup> - 35:8, 93:7</p> <p><b>injury</b> <sup>[12]</sup> - 35:14, 72:20, 81:14, 82:4, 86:2, 92:8, 92:10, 92:15, 93:2, 93:6, 94:6, 124:22</p> <p><b>inputs</b> <sup>[3]</sup> - 130:24, 131:5, 131:15</p> <p><b>Inspector</b> <sup>[11]</sup> - 106:6</p> <p><b>instance</b> <sup>[5]</sup> - 56:2, 62:22, 124:12, 125:18, 140:11</p> <p><b>instead</b> <sup>[5]</sup> - 78:17, 120:23, 121:14, 126:14, 127:23</p> <p><b>Institute</b> <sup>[3]</sup> - 78:4, 115:13, 119:21</p> <p><b>instructed</b> <sup>[11]</sup> - 17:17</p> <p><b>instructions</b> <sup>[11]</sup> - 152:16</p> <p><b>instrumentality</b> <sup>[11]</sup> - 94:13</p> <p><b>insufficient</b> <sup>[4]</sup> - 141:20, 141:22, 150:9, 152:2</p> <p><b>insufficient"</b> <sup>[11]</sup> - 128:23</p> <p><b>insurance</b> <sup>[6]</sup> - 35:18, 123:16, 123:17, 123:18, 123:21, 124:13</p>	<p><b>intend</b> <sup>[4]</sup> - 11:23, 11:24, 13:16, 152:22</p> <p><b>intended</b> <sup>[2]</sup> - 90:22, 142:6</p> <p><b>interest</b> <sup>[2]</sup> - 17:11, 137:11</p> <p><b>interference</b> <sup>[2]</sup> - 89:24, 137:14</p> <p><b>intermediate</b> <sup>[11]</sup> - 11:9</p> <p><b>internet</b> <sup>[8]</sup> - 48:15, 48:17, 98:22, 98:24, 98:25, 99:3, 99:5, 99:7</p> <p><b>interpreting</b> <sup>[11]</sup> - 131:24</p> <p><b>interrupt</b> <sup>[2]</sup> - 14:18, 14:20</p> <p><b>intervening</b> <sup>[15]</sup> - 67:15, 67:16, 71:6, 71:7, 80:14, 81:10, 81:19, 82:10, 82:13, 83:14, 94:22, 116:25, 120:13, 136:25, 137:4</p> <p><b>intervention</b> <sup>[11]</sup> - 65:24</p> <p><b>interventions</b> <sup>[11]</sup> - 17:18</p> <p><b>Intractable</b> <sup>[3]</sup> - 19:11, 19:23, 21:6</p> <p><b>intractable</b> <sup>[2]</sup> - 21:7, 21:10</p> <p><b>inventory</b> <sup>[11]</sup> - 60:10</p> <p><b>investigated</b> <sup>[2]</sup> - 49:24, 49:25</p> <p><b>investigation</b> <sup>[5]</sup> - 45:3, 47:13, 51:22, 53:13, 106:4</p> <p><b>investigations</b> <sup>[11]</sup> - 47:24</p> <p><b>investigative</b> <sup>[3]</sup> - 53:17, 53:21, 53:24</p> <p><b>investigator</b> <sup>[11]</sup> - 41:11</p> <p><b>investigators</b> <sup>[2]</sup> - 45:5, 53:25</p> <p><b>invoked</b> <sup>[11]</sup> - 67:9</p> <p><b>involved</b> <sup>[8]</sup> - 40:22, 44:17, 72:23, 85:5, 85:22, 92:23, 104:23, 109:12</p> <p><b>involves</b> <sup>[2]</sup> - 80:14, 82:17</p> <p><b>involving</b> <sup>[3]</sup> - 92:3, 112:11, 113:13</p> <p><b>ipse</b> <sup>[11]</sup> - 8:22</p> <p><b>Irpino</b> <sup>[11]</sup> - 3:7</p> <p><b>irrelevant</b> <sup>[3]</sup> - 62:23, 65:11, 111:4</p> <p><b>ISIA</b> <sup>[11]</sup> - 5:4</p>	<p><b>Island</b> <sup>[2]</sup> - 93:20, 131:7</p> <p><b>issue</b> <sup>[31]</sup> - 10:6, 15:8, 24:10, 48:15, 49:12, 64:3, 65:18, 67:22, 68:4, 68:13, 69:16, 79:4, 81:21, 81:22, 82:15, 82:24, 83:11, 85:7, 85:9, 86:15, 86:16, 105:6, 114:3, 114:10, 117:2, 117:5, 120:9, 124:2, 124:10, 136:21, 149:17</p> <p><b>issued</b> <sup>[10]</sup> - 17:16, 18:14, 20:3, 23:20, 23:25, 31:18, 76:9, 88:14, 88:24, 93:19</p> <p><b>issues</b> <sup>[14]</sup> - 7:10, 11:23, 62:17, 71:19, 72:14, 73:15, 92:25, 93:3, 102:14, 111:3, 130:9, 133:22, 134:2, 134:13</p> <p><b>itself</b> <sup>[8]</sup> - 13:10, 25:11, 40:21, 43:12, 68:3, 68:18, 85:3, 117:11</p> <p><b>IV</b> <sup>[11]</sup> - 64:18</p>	<p>17:24, 18:10, 57:19, 58:6, 59:18, 59:20, 67:10, 83:3, 83:7, 83:11, 83:17, 83:19, 89:5</p> <p><b>jointly</b> <sup>[3]</sup> - 42:19, 85:20, 85:25</p> <p><b>joke</b> <sup>[11]</sup> - 106:11</p> <p><b>JOSEPH</b> <sup>[11]</sup> - 6:4</p> <p><b>Joseph</b> <sup>[11]</sup> - 60:21</p> <p><b>JR</b> <sup>[2]</sup> - 2:3, 2:12</p> <p><b>Juan</b> <sup>[2]</sup> - 2:5, 2:14</p> <p><b>Judge</b> <sup>[24]</sup> - 7:2, 57:7, 57:19, 57:20, 58:1, 67:9, 67:11, 67:14, 67:15, 83:7, 83:24, 138:23, 140:4, 141:5, 141:18, 141:21, 142:9, 143:24, 146:22, 147:13, 147:18, 149:21, 150:6, 152:2</p> <p><b>JUDGE</b> <sup>[11]</sup> - 1:17</p> <p><b>judge</b> <sup>[11]</sup> - 149:2</p> <p><b>judgment</b> <sup>[7]</sup> - 58:8, 67:16, 74:23, 76:3, 81:20, 87:22, 94:22</p> <p><b>judgments</b> <sup>[10]</sup> - 74:11, 76:4, 81:11, 89:14, 90:4, 91:8, 95:12, 137:1, 137:19, 137:24</p> <p><b>Judith</b> <sup>[11]</sup> - 64:18</p> <p><b>July</b> <sup>[3]</sup> - 7:4, 154:7, 154:11</p> <p><b>JULY</b> <sup>[11]</sup> - 1:19</p> <p><b>June</b> <sup>[11]</sup> - 131:7</p> <p><b>jurisdiction</b> <sup>[11]</sup> - 58:18</p>	<p>101:20, 128:13</p> <p><b>Keyes</b> <sup>[15]</sup> - 25:6, 32:3, 35:9, 63:19, 64:1, 74:2, 76:13, 76:19, 77:23, 79:2, 81:22, 82:6, 109:21, 119:13</p> <p><b>kind</b> <sup>[9]</sup> - 63:23, 64:4, 93:3, 101:11, 112:18, 116:10, 122:5, 130:21, 149:11</p> <p><b>kinds</b> <sup>[3]</sup> - 51:2, 93:15, 103:20</p> <p><b>kit</b> <sup>[11]</sup> - 17:17</p> <p><b>knowing</b> <sup>[2]</sup> - 60:12, 129:18</p> <p><b>knowledge</b> <sup>[11]</sup> - 62:15</p> <p><b>known</b> <sup>[3]</sup> - 27:10, 27:11, 103:1</p> <p><b>knows</b> <sup>[5]</sup> - 10:18, 12:11, 12:23, 31:22, 57:7</p> <p><b>KOUBA</b> <sup>[11]</sup> - 4:11</p> <p><b>Kyle</b> <sup>[11]</sup> - 42:8</p>
<b>J</b>				
<p><b>Jack</b> <sup>[3]</sup> - 131:11, 131:12, 132:11</p> <p><b>Jackie</b> <sup>[11]</sup> - 148:2</p> <p><b>Jackson</b> <sup>[11]</sup> - 6:8</p> <p><b>Jakki</b> <sup>[11]</sup> - 8:13</p> <p><b>James</b> <sup>[2]</sup> - 35:17, 145:6</p> <p><b>January</b> <sup>[11]</sup> - 131:4</p> <p><b>JASIEWICZ</b> <sup>[11]</sup> - 5:4</p> <p><b>JCAHO</b> <sup>[11]</sup> - 57:9</p> <p><b>JEFFREY</b> <sup>[11]</sup> - 5:13</p> <p><b>JENNIFER</b> <sup>[11]</sup> - 4:18</p> <p><b>Jennings</b> <sup>[2]</sup> - 148:7, 148:12</p> <p><b>Jersey</b> <sup>[11]</sup> - 48:18</p> <p><b>Jesse</b> <sup>[2]</sup> - 8:3, 54:2</p> <p><b>job</b> <sup>[5]</sup> - 40:23, 80:4, 134:18, 146:25, 150:15</p> <p><b>jobs</b> <sup>[11]</sup> - 35:7</p> <p><b>Joe</b> <sup>[11]</sup> - 60:20</p> <p><b>Johns</b> <sup>[11]</sup> - 17:7</p> <p><b>joined</b> <sup>[11]</sup> - 20:21</p> <p><b>joint</b> <sup>[9]</sup> - 18:14, 20:4, 21:13, 85:8, 85:12, 85:15, 86:5, 86:7, 86:9</p> <p><b>Joint</b> <sup>[14]</sup> - 17:22,</p>				
<b>K</b>				
<p><b>Katherine</b> <sup>[11]</sup> - 25:6</p> <p><b>Kave</b> <sup>[3]</sup> - 8:3, 8:6, 54:2</p> <p><b>Kearse</b> <sup>[5]</sup> - 10:3, 62:1, 73:11, 121:1, 147:7</p> <p><b>KEARSE</b> <sup>[11]</sup> - 4:2</p> <p><b>keep</b> <sup>[5]</sup> - 30:8, 109:6, 111:20, 139:8, 145:3</p> <p><b>Keller</b> <sup>[7]</sup> - 13:18, 13:21, 30:6, 30:9, 30:11, 30:20, 75:15</p> <p><b>Kelly</b> <sup>[11]</sup> - 6:8</p> <p><b>kept</b> <sup>[2]</sup> - 45:16, 78:12</p> <p><b>Kessler</b> <sup>[11]</sup> - 4:23</p> <p><b>Kevin</b> <sup>[11]</sup> - 25:15</p> <p><b>key</b> <sup>[10]</sup> - 12:5, 21:22, 32:13, 36:22, 41:5, 78:8, 89:4, 89:14,</p>				
<b>L</b>				
<p><b>LA</b> <sup>[11]</sup> - 3:8</p> <p><b>labeling</b> <sup>[11]</sup> - 87:9</p> <p><b>laced</b> <sup>[11]</sup> - 62:6</p> <p><b>Lacey</b> <sup>[11]</sup> - 75:15</p> <p><b>lack</b> <sup>[5]</sup> - 57:10, 81:3, 97:12, 100:24, 105:14</p> <p><b>Lake</b> <sup>[11]</sup> - 149:19</p> <p><b>Lakeland</b> <sup>[11]</sup> - 49:3</p> <p><b>land</b> <sup>[11]</sup> - 139:13</p> <p><b>language</b> <sup>[4]</sup> - 81:12, 94:7, 103:14, 116:23</p> <p><b>LANIER</b> <sup>[11]</sup> - 3:4</p> <p><b>lap</b> <sup>[11]</sup> - 135:20</p> <p><b>Large</b> <sup>[11]</sup> - 47:18</p> <p><b>large</b> <sup>[5]</sup> - 19:6, 19:7, 28:9, 47:20, 93:21</p> <p><b>larger</b> <sup>[11]</sup> - 102:4</p> <p><b>largest</b> <sup>[2]</sup> - 97:16, 100:22</p> <p><b>last</b> <sup>[11]</sup> - 15:24, 23:16, 25:14, 57:7, 61:19, 88:14, 89:10, 120:16, 126:11, 129:12, 150:21</p> <p><b>late</b> <sup>[3]</sup> - 25:7, 25:17, 70:2</p> <p><b>Latin</b> <sup>[11]</sup> - 151:15</p> <p><b>Laughter</b> <sup>[11]</sup> - 153:16</p> <p><b>launched</b> <sup>[11]</sup> - 16:24</p> <p><b>LAURA</b> <sup>[11]</sup> - 5:10</p> <p><b>Law</b> <sup>[3]</sup> - 3:4, 3:7, 3:12</p>				



<p><u>law</u> [37] - 40:8, 50:22, 57:13, 57:17, 63:3, 68:1, 70:15, 72:12, 81:2, 81:12, 84:8, 84:10, 84:18, 84:22, 84:24, 89:18, 90:22, 91:6, 92:14, 92:15, 92:19, 93:14, 94:8, 94:11, 100:19, 117:9, 117:11, 122:12, 124:20, 132:1, 132:4, 135:8, 137:17, 137:20, 137:21, 137:23, 143:1</p> <p><u>lawful</u> [1] - 114:23</p> <p><u>laws</u> [2] - 21:15, 22:13</p> <p><u>lawsuit</u> [1] - 29:19</p> <p><u>lawyer</u> [1] - 44:7</p> <p><u>lawyers</u> [1] - 153:12</p> <p><u>lead</u> [6] - 93:18, 94:3, 107:12, 117:7, 118:10</p> <p><u>leaders</u> [1] - 60:17</p> <p><u>leadership</u> [1] - 40:10</p> <p><u>leading</u> [1] - 15:17</p> <p><u>leads</u> [1] - 34:17</p> <p><u>League</u> [1] - 66:13</p> <p><u>learned</u> [1] - 44:13</p> <p><u>least</u> [5] - 61:23, 62:13, 91:14, 107:3, 113:18</p> <p><u>leave</u> [6] - 75:7, 78:25, 79:14, 79:17, 80:18, 109:22</p> <p><u>leaves</u> [1] - 61:1</p> <p><u>leaving</u> [1] - 79:11</p> <p><u>lecture</u> [1] - 22:11</p> <p><u>led</u> [8] - 17:7, 23:25, 24:17, 35:20, 40:7, 78:14, 78:24, 114:20</p> <p><u>Lee</u> [1] - 3:12</p> <p><u>left</u> [9] - 11:14, 32:23, 78:22, 79:5, 79:9, 79:10, 108:18, 135:1, 138:1</p> <p><u>leftovers</u> [2] - 66:25, 67:1</p> <p><u>legal</u> [10] - 56:21, 63:10, 73:2, 73:16, 73:17, 80:25, 86:15, 93:3, 110:17, 120:18</p> <p><u>Legislature</u> [5] - 19:9, 20:15, 21:5, 23:3, 24:4</p> <p><u>legitimate</u> [21] - 9:16, 9:19, 16:15, 28:3, 28:4, 28:24, 31:8, 31:14, 31:19, 50:8, 76:10, 87:20, 88:7,</p>	<p>91:3, 91:7, 91:8, 91:12, 91:13, 100:15, 116:18, 145:3</p> <p><u>legitimacy</u> [1] - 76:12</p> <p><u>Lemley</u> [1] - 114:6</p> <p><u>length</u> [2] - 130:6, 142:15</p> <p><u>Leon</u> [2] - 2:4, 2:14</p> <p><u>lepers</u> [3] - 151:9, 151:18, 151:22</p> <p><u>Lepers</u> [1] - 151:14</p> <p><u>lepra</u> [1] - 151:16</p> <p><u>leprosy</u> [3] - 151:19, 151:21, 151:22</p> <p><u>less</u> [8] - 21:9, 21:11, 95:6, 104:18, 105:19, 138:23, 147:16, 153:15</p> <p><u>letter</u> [1] - 21:1</p> <p><u>level</u> [17] - 17:2, 17:19, 26:19, 75:9, 75:25, 76:1, 96:24, 100:6, 101:10, 103:2, 113:14, 121:13, 129:6, 134:7, 149:7</p> <p><u>levels</u> [6] - 35:15, 115:10, 136:2, 136:3, 149:9, 150:3</p> <p><u>Levin</u> [2] - 2:10, 132:2</p> <p><u>LEYIMU</u> [1] - 4:13</p> <p><u>liability</u> [18] - 9:3, 12:4, 57:1, 62:23, 63:3, 65:11, 85:8, 85:12, 85:15, 86:5, 86:8, 86:10, 92:14, 92:20, 93:8, 99:18, 112:11, 122:10</p> <p><u>liable</u> [9] - 61:18, 67:6, 73:8, 85:20, 85:25, 120:6, 122:5, 122:20, 147:14</p> <p><u>liberal</u> [1] - 24:18</p> <p><u>liberally</u> [1] - 21:25</p> <p><u>license</u> [1] - 69:8</p> <p><u>licensed</u> [12] - 12:7, 12:9, 21:2, 31:2, 54:17, 60:3, 60:4, 66:23, 66:24, 67:7, 110:15, 115:18</p> <p><u>licenses</u> [2] - 22:12, 23:15</p> <p><u>Licensing</u> [1] - 23:4</p> <p><u>lies</u> [1] - 64:21</p> <p><u>life</u> [4] - 16:23, 19:5, 20:5, 64:8</p> <p><u>light</u> [1] - 26:10</p> <p><u>likely</u> [7] - 71:21, 103:8, 103:9,</p>	<p>103:11, 104:1, 106:25, 107:1</p> <p><u>likewise</u> [4] - 71:18, 76:15, 76:16, 82:22</p> <p><u>Limit</u> [3] - 40:16, 41:12</p> <p><u>limit</u> [3] - 40:19, 125:22, 126:5</p> <p><u>limited</u> [4] - 19:15, 19:25, 24:6, 35:23</p> <p><u>limits</u> [5] - 23:21, 23:22, 40:18, 59:1, 125:24</p> <p><u>LINDA</u> [1] - 4:8</p> <p><u>line</u> [8] - 24:21, 27:25, 28:1, 46:25, 50:12, 55:17, 94:15, 147:8</p> <p><u>lining</u> [1] - 30:6</p> <p><u>link</u> [3] - 11:4, 60:7, 65:2</p> <p><u>linkage</u> [1] - 72:19</p> <p><u>linking</u> [1] - 102:19</p> <p><u>links</u> [3] - 60:1, 99:7, 99:11</p> <p><u>Lisa</u> [2] - 6:18, 154:1</p> <p><u>list</u> [1] - 129:22</p> <p><u>listen</u> [1] - 139:2</p> <p><u>listening</u> [1] - 147:17</p> <p><u>lit</u> [1] - 8:12</p> <p><u>literally</u> [1] - 65:5</p> <p><u>litigation</u> [10] - 35:11, 50:18, 51:7, 57:9, 65:14, 107:23, 112:8, 112:9, 112:18, 131:4</p> <p><u>live</u> [4] - 7:21, 7:25, 8:1, 44:2</p> <p><u>lived</u> [2] - 54:5, 148:2</p> <p><u>LLC</u> [1] - 2:4</p> <p><u>local</u> [3] - 25:15, 25:19, 32:5</p> <p><u>locate</u> [1] - 106:16</p> <p><u>Logan</u> [8] - 6:5, 6:12, 145:18, 145:21, 146:8, 146:12, 146:13, 146:16</p> <p><u>look</u> [30] - 27:15, 30:3, 37:7, 46:19, 49:17, 49:19, 49:21, 52:17, 64:2, 68:14, 85:21, 90:18, 96:4, 96:22, 97:3, 125:9, 125:20, 126:1, 126:13, 129:2, 131:21, 140:4, 140:5, 141:4, 141:5, 145:23, 148:12, 149:7, 149:8, 149:9</p> <p><u>looked</u> [11] - 28:18, 28:21, 36:25, 38:16,</p>	<p>51:15, 63:14, 66:5, 84:16, 93:4, 125:15, 126:8</p> <p><u>looking</u> [10] - 33:4, 46:9, 59:9, 63:16, 75:18, 96:20, 99:10, 106:21, 106:23, 149:15</p> <p><u>looks</u> [1] - 101:11</p> <p><u>lose</u> [1] - 150:14</p> <p><u>lost</u> [2] - 69:8, 152:1</p> <p><u>loud</u> [1] - 25:8</p> <p><u>low</u> [2] - 63:19, 117:17</p> <p><u>lower</u> [4] - 17:3, 113:5, 113:7, 115:11</p> <p><u>Luken</u> [4] - 101:2, 101:13, 102:5, 102:14</p> <p><u>lunch</u> [2] - 70:3, 70:4</p>	<p>59:8, 59:10</p> <p><u>manufacturers</u> [3] - 59:18, 68:24, 101:24</p> <p><u>manufacturers'</u> [1] - 59:14</p> <p><u>map</u> [1] - 65:5</p> <p><u>Mapes</u> [3] - 41:10, 41:20, 42:8</p> <p><u>March</u> [1] - 131:2</p> <p><u>marijuana</u> [1] - 64:5</p> <p><u>MARK</u> [1] - 3:14</p> <p><u>market</u> [6] - 58:25, 65:24, 115:8, 117:17, 120:1, 143:7</p> <p><u>marketing</u> [7] - 8:13, 8:14, 59:8, 59:11, 59:15, 115:14</p> <p><u>marketplace</u> [2] - 76:5, 91:22</p> <p><u>markets</u> [1] - 140:10</p> <p><u>marry</u> [1] - 9:25</p> <p><u>Marshall</u> [2] - 24:16, 25:15</p> <p><u>Marshall's</u> [1] - 60:22</p> <p><u>Maryland</u> [1] - 148:4</p> <p><u>mass</u> [1] - 92:18</p> <p><u>Masters</u> [2] - 104:13, 139:14</p> <p><u>match</u> [3] - 14:4, 30:19, 30:21</p> <p><u>match-up</u> [1] - 14:4</p> <p><u>matched</u> [1] - 13:25</p> <p><u>matches</u> [1] - 27:25</p> <p><u>math</u> [2] - 30:10, 30:11</p> <p><u>Matt</u> [1] - 47:11</p> <p><u>matter</u> [4] - 67:24, 69:19, 143:4, 154:3</p> <p><u>mattered</u> [1] - 106:18</p> <p><u>matters</u> [3] - 69:1, 69:2, 70:6</p> <p><u>mayor</u> [1] - 123:8</p> <p><u>Mayor</u> [10] - 18:9, 32:10, 36:4, 36:8, 59:14, 60:17, 76:15, 115:4, 130:10, 134:1</p> <p><u>McCann</u> [18] - 8:17, 13:18, 13:19, 13:20, 14:13, 14:14, 16:6, 29:13, 30:7, 30:15, 33:5, 33:9, 48:20, 55:23, 75:18, 96:20, 97:20, 98:15</p> <p><u>McCann's</u> [2] - 14:16, 32:25</p> <p><u>MCCLURE</u> [1] - 6:3</p> <p><u>McDonald</u> [3] - 36:25, 37:4, 50:23</p> <p><u>MCGINNESS</u> [1] - 4:2</p> <p><u>McKesson</u> [36] - 5:8,</p>
---	--	--	--	---

7:20, 30:25, 95:18,  
96:2, 97:15, 97:18,  
97:23, 98:6, 98:7,  
98:9, 98:14, 99:11,  
99:19, 99:22,  
100:20, 102:5,  
102:12, 102:15,  
102:24, 103:7,  
103:25, 104:17,  
104:22, 104:25,  
105:3, 105:5, 105:8,  
106:1, 108:25,  
110:15, 110:17,  
110:22, 144:8,  
144:17, 144:18

**McKesson's** [16] -  
71:15, 71:18, 95:15,  
95:19, 95:21, 95:22,  
95:24, 96:4, 98:2,  
99:13, 100:3,  
100:14, 100:18,  
103:3, 103:5, 104:24  
**mean** [2] - 134:25,  
141:16

**meaningful** [1] - 8:23  
**meant** [2] - 17:1, 53:7  
**measure** [1] - 149:6  
**measured** [1] - 13:12  
**measurements** [3] -  
46:13, 149:4, 149:5  
**measuring** [1] - 119:1  
**mechanical** [1] - 6:19  
**mechanism** [1] -  
124:23  
**mechanisms** [1] -  
112:10

**Medicaid** [3] - 35:18,  
45:5, 68:21

**medical** [52] - 9:16,  
22:21, 23:17, 25:4,  
25:25, 27:5, 28:3,  
28:4, 28:14, 28:24,  
31:14, 31:19, 36:12,  
50:8, 58:8, 60:22,  
63:9, 63:15, 67:16,  
69:12, 71:13, 73:19,  
74:11, 74:23, 76:10,  
77:9, 78:15, 78:19,  
81:10, 81:20, 87:20,  
87:24, 88:7, 88:9,  
89:4, 89:14, 89:23,  
90:4, 90:19, 91:8,  
94:20, 94:21, 94:22,  
95:12, 100:15,  
108:2, 116:1,  
116:18, 136:25,  
137:10, 137:18,  
145:4

**Medical** [2] - 15:19,  
24:16

**medically** [2] - 32:8,  
77:7

**Medicare** [1] - 124:13  
**medication** [9] - 9:20,  
19:6, 27:9, 39:17,  
60:3, 60:5, 61:3,  
61:7, 63:1

**medications** [15] -  
12:11, 16:14, 18:19,  
26:6, 26:17, 32:2,  
34:10, 36:22, 37:11,  
37:20, 51:3, 56:9,  
60:12, 77:25, 100:15

**medicinal** [1] - 91:21  
**medicine** [28] - 60:25,  
61:1, 61:9, 66:25,  
71:1, 78:23, 79:6,  
80:12, 80:14, 80:22,  
82:16, 85:5, 89:22,  
90:5, 95:1, 95:3,  
95:5, 95:7, 107:8,  
111:12, 116:17,  
117:20, 136:12,  
137:5, 137:8,  
137:22, 148:21

**Medicine** [27] - 19:2,  
20:3, 20:9, 20:18,  
21:1, 21:12, 21:24,  
22:11, 24:20, 51:13,  
52:1, 52:3, 52:5,  
52:8, 53:8, 53:20,  
54:5, 54:6, 54:12,  
54:16, 88:15, 88:18,  
88:24, 88:25, 89:5,  
118:4, 137:25

**medicines** [16] -  
71:12, 73:12, 87:10,  
87:19, 89:7, 89:16,  
90:3, 90:20, 91:1,  
91:18, 110:25,  
114:23, 137:15,  
138:1, 138:2, 141:24

**medicines"** [1] -  
137:12  
**meet** [8] - 9:16, 28:13,  
50:8, 87:23, 88:7,  
90:2, 94:21, 114:18

**meeting** [2] - 43:11,  
43:20

**men** [1] - 151:18

**mention** [3] - 47:3,  
55:16, 139:12

**mentioned** [8] - 27:21,  
47:4, 51:11, 52:18,  
73:11, 96:1, 99:23,  
139:15

**mentioning** [1] - 73:11

**merits** [1] - 136:7

**met** [1] - 45:19

**metaphor** [1] - 149:11

**metastasized** [1] -  
139:23

**meth** [1] - 114:5

**Method** [1] - 50:25

**method** [1] - 108:14

**methodologies** [2] -  
50:16, 51:6

**methodology** [22] -  
49:20, 49:22, 50:14,  
50:24, 51:3, 51:4,  
107:16, 107:21,  
108:6, 108:12,  
108:22, 109:15,  
125:11, 128:14,  
130:17, 130:18,  
131:18, 131:20,  
132:13, 134:25,  
135:7

**Methodology** [1] -  
50:24

**methods** [1] - 107:23

**metrics** [2] - 46:14,  
147:2

**Mexican** [1] - 116:13

**Mexico** [2] - 67:4,  
117:16

**Miami** [4] - 101:2,  
101:13, 102:5,  
102:14

**Miami-Luken** [4] -  
101:2, 101:13,  
102:5, 102:14

**MICHAEL** [2] - 2:12,  
3:9

**Michael** [3] - 8:2,  
41:10, 44:2

**Michigan** [1] - 104:7

**mid** [1] - 15:23

**middle** [1] - 32:25

**might** [7] - 19:17,  
20:8, 39:1, 41:4,  
101:12, 103:19,  
115:15

**MILDRED** [1] - 3:3

**miles** [1] - 98:10

**mill** [1] - 76:19

**million** [19] - 73:6,  
96:1, 96:3, 97:18,  
97:24, 99:18, 101:6,  
113:6, 126:3, 126:5,  
126:9, 126:14,  
126:25, 127:8,  
128:6, 133:23,  
134:8, 143:21, 150:5

**mind** [4] - 19:16,  
60:24, 142:18,  
151:12

**miners** [1] - 60:14

**minute** [3] - 141:12,  
145:5, 145:19

**minutes** [3] - 73:10,  
111:24, 138:23

**mirror** [1] - 10:23

**misconduct** [4] - 55:9,  
65:21, 100:4, 100:12

**misleading** [1] - 8:14

**misrepresentations**  
[1] - 139:5

**missed** [1] - 128:7

**missing** [2] - 26:25,  
102:7

**mission** [1] - 151:24

**mistake** [4] - 78:19,  
145:25, 146:5, 146:6

**misuse** [8] - 58:16,  
59:25, 63:9, 63:15,  
63:17, 63:20, 82:19,  
113:24

**misuse"** [1] - 78:7

**misused** [3] - 20:8,  
111:13, 116:1

**misuses** [1] - 80:6

**misusing** [1] - 11:11

**Mitchell** [1] - 2:10

**MMEs** [1] - 97:24

**model** [25] - 43:4,  
125:10, 126:21,  
126:22, 127:9,  
128:18, 128:19,  
129:11, 130:16,  
130:21, 130:22,  
130:23, 130:24,  
131:1, 131:3, 131:4,  
131:8, 131:10,  
131:11, 131:17,  
132:6, 132:17,  
132:21, 132:22,  
133:7

**Mohr** [1] - 8:13

**molecules** [1] - 25:2

**Mone** [15] - 8:2, 8:6,  
40:4, 44:2, 44:3,  
45:14, 45:17, 45:19,  
45:22, 46:5, 46:7,  
51:17, 51:19, 53:14

**monetary** [1] - 77:25

**money** [10] - 104:5,  
121:1, 121:15,  
122:25, 123:13,  
124:21, 124:24,  
125:20, 134:17,  
147:16

**monitor** [4] - 27:13,  
145:10, 150:16

**monitored** [1] - 54:4

**Monitoring** [10] -  
12:25, 23:3, 38:10,  
39:25, 40:11, 42:16,  
43:23, 54:20, 61:21,  
104:25

**monitoring** [8] -  
42:18, 42:23, 44:11,  
44:22, 47:13, 110:1,  
148:16, 148:20

**monster** [1] - 94:10

**month** [8] - 52:23,  
108:14, 108:16,  
108:19, 140:21,  
145:17, 145:20,  
146:11

**month's** [1] - 108:20

**monthly** [1] - 40:15

**Morgantown** [1] -  
148:2

**morning** [2] - 7:6,  
115:24

**morphine** [4] - 140:7,  
140:16, 140:23,  
141:12

**Morris** [1] - 6:15

**most** [8] - 18:19,  
18:20, 24:20, 114:4,  
119:5, 119:14,  
133:16, 138:12

**Most** [1] - 7:11

**motion** [5] - 84:2,  
86:23, 92:1, 120:17,  
125:9

**motions** [4] - 91:25,  
136:23, 138:4,  
152:23

**Motley** [5] - 4:3, 4:5,  
4:8, 4:11, 4:14

**MOUGEY** [1] - 2:9

**Mountain** [1] - 113:3

**mouthful** [1] - 23:5

**move** [2] - 112:4,  
147:5

**moved** [4] - 23:18,  
45:10, 113:7, 114:6

**moving** [1] - 114:13

**MR** [48] - 2:3, 2:6, 2:9,  
2:12, 3:9, 3:11, 3:14,  
4:5, 4:22, 5:9, 5:10,  
5:13, 6:4, 70:1, 70:9,  
70:12, 70:14, 86:19,  
86:22, 87:2, 92:24,  
93:12, 96:15, 97:11,  
111:23, 112:2,  
138:15, 138:18,  
138:20, 138:23,  
139:1, 140:15,  
142:9, 142:21,  
142:24, 143:10,  
146:15, 146:22,  
147:2, 147:24,  
148:9, 152:12,  
152:14, 152:20,  
152:24, 152:25,  
153:2, 153:9

**MS** <sup>[30]</sup> - 3:3, 3:6, 4:2, 4:8, 4:11, 4:13, 4:17, 4:18, 4:20, 5:3, 5:4, 5:10, 6:3, 6:7, 6:14, 7:8, 10:10, 10:13, 13:11, 14:21, 14:25, 19:21, 38:14, 38:18, 38:23, 39:5, 39:10, 39:22, 42:6, 152:13  
**Mt** <sup>[3]</sup> - 4:4, 4:12, 4:15  
**Muhury** <sup>[3]</sup> - 63:11, 63:13, 63:24  
**multiple** <sup>[14]</sup> - 23:8, 53:2, 58:7, 64:15, 71:8, 72:23, 77:19, 82:17, 82:21, 84:6, 85:4, 85:22, 136:14, 137:4  
**multiplier** <sup>[2]</sup> - 46:1, 46:2  
**multiply** <sup>[1]</sup> - 127:7  
**Murphy** <sup>[6]</sup> - 39:2, 39:12, 64:6, 65:4, 74:24, 75:8  
**Murphy's** <sup>[2]</sup> - 38:25, 39:18  
**must** <sup>[6]</sup> - 12:2, 26:20, 43:16, 81:4, 128:5, 135:3

## **N**

**named** <sup>[2]</sup> - 40:8, 45:18  
**namely** <sup>[1]</sup> - 83:15  
**names** <sup>[1]</sup> - 98:9  
**Narcotic** <sup>[2]</sup> - 140:18, 143:2  
**narcotics** <sup>[1]</sup> - 143:6  
**nation** <sup>[4]</sup> - 32:19, 33:16, 34:22, 74:1  
**national** <sup>[5]</sup> - 34:14, 38:1, 73:23, 88:9, 145:23  
**National** <sup>[4]</sup> - 66:13, 78:4, 115:13, 119:21  
**nationally** <sup>[6]</sup> - 16:1, 18:23, 29:7, 31:6, 33:7, 33:21  
**nationwide** <sup>[2]</sup> - 32:24, 33:3  
**nature** <sup>[2]</sup> - 140:1, 151:4  
**near** <sup>[1]</sup> - 43:20  
**nearly** <sup>[3]</sup> - 31:17, 37:15, 76:9  
**necessarily** <sup>[2]</sup> - 56:22, 65:9  
**necessary** <sup>[5]</sup> - 9:16, 77:7, 88:7, 90:16

**necessity** <sup>[1]</sup> - 81:7  
**need** <sup>[30]</sup> - 14:19, 28:4, 28:24, 71:13, 94:21, 111:2, 111:21, 116:18, 120:8, 120:14, 124:7, 124:11, 124:15, 125:16, 125:19, 125:23, 126:8, 129:24, 133:18, 134:17, 134:19, 136:5, 137:12, 138:16, 143:25, 144:1, 144:23, 144:24, 152:3, 152:15  
**needed** <sup>[11]</sup> - 50:11, 75:7, 76:3, 78:22, 79:22, 90:3, 124:12, 125:15, 126:15, 135:6, 153:2  
**needs** <sup>[14]</sup> - 9:16, 11:20, 28:3, 28:14, 50:8, 87:20, 87:24, 88:8, 89:23, 108:3, 110:24, 134:3, 134:13, 145:4  
**neighboring** <sup>[1]</sup> - 36:11  
**nerd** <sup>[1]</sup> - 148:11  
**neutral** <sup>[1]</sup> - 103:19  
**never** <sup>[26]</sup> - 12:17, 25:22, 27:13, 27:14, 48:23, 55:12, 56:6, 60:8, 72:19, 73:11, 77:8, 94:8, 101:5, 107:21, 111:8, 111:15, 121:23, 122:15, 122:18, 122:21, 123:8, 123:9, 124:11, 130:14, 130:15, 132:7  
**new** <sup>[15]</sup> - 23:20, 42:19, 43:4, 43:15, 43:19, 44:18, 44:19, 45:10, 46:14, 46:16, 56:3, 102:16, 111:19, 122:7, 122:12  
**New** <sup>[4]</sup> - 3:5, 3:8, 48:18, 51:7  
**newsletter** <sup>[1]</sup> - 21:1  
**next** <sup>[12]</sup> - 19:9, 30:8, 42:18, 112:4, 112:20, 126:4, 139:16, 140:13, 142:3, 146:11, 148:9, 149:10  
**nice** <sup>[1]</sup> - 115:23

**nicely** <sup>[1]</sup> - 119:19  
**Nicholas** <sup>[7]</sup> - 13:15, 13:16, 30:4, 30:17, 41:15, 41:16, 42:17  
**NICHOLAS** <sup>[1]</sup> - 6:11  
**nine** <sup>[3]</sup> - 83:6, 98:9, 98:17  
**Ninth** <sup>[1]</sup> - 4:9  
**no-due-diligence** <sup>[1]</sup> - 108:10  
**non** <sup>[6]</sup> - 32:2, 35:20, 35:25, 63:9, 96:14, 116:1  
**non-cancer** <sup>[1]</sup> - 32:2  
**non-medical** <sup>[2]</sup> - 63:9, 116:1  
**non-opioid** <sup>[2]</sup> - 35:20, 35:25  
**non-VA** <sup>[1]</sup> - 96:14  
**None** <sup>[3]</sup> - 7:23, 11:15, 11:16  
**none** <sup>[4]</sup> - 48:19, 99:23, 108:15, 130:13  
**nonetheless** <sup>[2]</sup> - 86:4, 144:18  
**normal** <sup>[2]</sup> - 103:17, 144:6  
**notable** <sup>[1]</sup> - 85:21  
**notably** <sup>[1]</sup> - 105:21  
**note** <sup>[2]</sup> - 127:6, 142:4  
**noted** <sup>[5]</sup> - 36:15, 73:24, 91:14, 91:24, 119:14  
**nothing** <sup>[12]</sup> - 8:22, 51:7, 53:11, 60:7, 62:6, 66:7, 83:23, 105:22, 106:19, 115:19, 135:15, 151:2  
**notice** <sup>[1]</sup> - 144:15  
**noting** <sup>[2]</sup> - 87:12, 115:2  
**nuisance** <sup>[43]</sup> - 71:11, 72:12, 87:4, 87:6, 89:15, 89:20, 89:22, 90:2, 90:11, 90:22, 91:5, 91:6, 91:10, 91:16, 91:24, 92:1, 92:5, 92:7, 92:9, 92:15, 93:15, 93:25, 94:5, 94:8, 94:17, 94:24, 95:6, 95:14, 110:24, 112:17, 121:9, 121:10, 121:18, 135:14, 135:18, 137:7, 137:8, 137:17, 137:20, 137:22, 137:23, 138:6

**Nuisance** <sup>[1]</sup> - 94:10  
**number** <sup>[49]</sup> - 9:25, 13:9, 15:3, 15:5, 22:5, 24:7, 30:17, 32:21, 34:6, 34:8, 34:22, 34:23, 34:24, 34:25, 35:1, 37:5, 37:10, 38:2, 38:3, 50:21, 52:21, 55:17, 56:7, 59:1, 61:14, 63:7, 65:22, 75:16, 85:17, 93:22, 126:6, 126:13, 126:16, 126:24, 126:25, 127:6, 127:7, 127:21, 127:25, 128:5, 128:6, 128:7, 130:2, 143:21, 150:17  
**numbers** <sup>[9]</sup> - 30:18, 35:3, 36:2, 46:12, 51:1, 65:1, 126:11, 128:2, 128:15  
**NW** <sup>[6]</sup> - 4:6, 4:9, 4:19, 4:21, 5:5, 5:12  
**NY** <sup>[1]</sup> - 3:5

## **O**

**O'Connell** <sup>[4]</sup> - 125:13, 125:17, 125:21, 130:6  
**obesity** <sup>[2]</sup> - 34:23, 91:14  
**objection** <sup>[1]</sup> - 105:2  
**objective** <sup>[2]</sup> - 133:6, 133:12  
**objectives** <sup>[2]</sup> - 133:15, 133:19  
**obligated** <sup>[1]</sup> - 28:3  
**obligation** <sup>[1]</sup> - 134:22  
**obligations** <sup>[1]</sup> - 144:13  
**observation** <sup>[1]</sup> - 75:22  
**obstacle** <sup>[1]</sup> - 115:21  
**obviously** <sup>[4]</sup> - 39:15, 49:11, 51:15, 135:8  
**Obviously** <sup>[1]</sup> - 61:16  
**occasionally** <sup>[1]</sup> - 48:7  
**occasions** <sup>[1]</sup> - 85:18  
**occur** <sup>[1]</sup> - 81:14  
**occurred** <sup>[5]</sup> - 81:25, 82:2, 82:4, 100:6, 111:14  
**occurring** <sup>[1]</sup> - 96:23  
**occurs** <sup>[2]</sup> - 80:4, 110:5  
**odds** <sup>[1]</sup> - 122:11  
**OF** <sup>[2]</sup> - 1:1, 1:4

**offense** <sup>[2]</sup> - 139:4, 141:18  
**offer** <sup>[2]</sup> - 8:22, 46:6  
**offered** <sup>[3]</sup> - 8:10, 129:10, 152:18  
**offering** <sup>[1]</sup> - 100:5  
**Office** <sup>[1]</sup> - 106:6  
**office** <sup>[1]</sup> - 44:8  
**Officer** <sup>[1]</sup> - 24:16  
**officer** <sup>[1]</sup> - 40:8  
**official** <sup>[1]</sup> - 19:10  
**Official** <sup>[2]</sup> - 153:25, 154:1  
**officials** <sup>[2]</sup> - 29:18, 47:19  
**often** <sup>[6]</sup> - 18:19, 18:20, 31:15, 37:15, 64:9, 115:2  
**Ohio** <sup>[2]</sup> - 51:7, 131:2  
**old** <sup>[6]</sup> - 99:9, 113:18, 121:22, 151:8, 151:20  
**older** <sup>[2]</sup> - 35:4, 35:14  
**on-going** <sup>[3]</sup> - 44:4, 44:19, 51:21  
**once** <sup>[3]</sup> - 79:14, 145:12, 146:18  
**oncology** <sup>[1]</sup> - 100:23  
**one** <sup>[93]</sup> - 7:13, 11:6, 14:4, 14:5, 14:12, 21:6, 23:22, 25:21, 29:12, 29:19, 30:2, 30:4, 31:15, 34:7, 34:8, 34:11, 34:22, 34:23, 34:24, 36:16, 36:17, 38:3, 44:10, 48:22, 51:3, 51:25, 52:18, 53:4, 56:23, 57:13, 57:15, 57:23, 59:3, 62:3, 63:23, 64:16, 65:17, 65:20, 66:14, 67:21, 68:23, 69:2, 69:4, 69:6, 69:7, 69:10, 70:6, 75:12, 75:24, 77:17, 86:18, 91:23, 92:3, 92:11, 93:1, 93:18, 94:11, 94:19, 100:13, 100:18, 106:3, 106:9, 108:5, 108:14, 108:17, 108:20, 109:19, 112:5, 119:5, 119:25, 125:7, 127:23, 128:1, 131:12, 131:13, 131:23, 131:24, 132:8, 139:7, 142:8, 143:1, 143:12, 143:21, 145:14

<p>145:17, 145:19, 149:10, 151:8 <b>One</b> [2] - 5:11, 17:6 <b>one's</b> [1] - 50:16 <b>one-sentence</b> [2] - 131:12, 131:13 <b>one-size-fits-all</b> [1] - 51:3 <b>one-to-one</b> [1] - 14:4 <b>ones</b> [2] - 64:10, 150:1 <b>ongoing</b> [1] - 123:24 <b>open</b> [1] - 149:20 <b>opening</b> [5] - 10:22, 16:5, 47:4, 72:8, 113:4 <b>operate</b> [1] - 110:25 <b>operated</b> [1] - 40:11 <b>operates</b> [1] - 130:25 <b>operating</b> [6] - 45:14, 67:4, 98:22, 99:3, 110:17, 130:2 <b>operator</b> [1] - 150:22 <b>opinion</b> [4] - 84:15, 108:1, 132:14, 142:15 <b>opinions</b> [2] - 8:10, 100:5 <b>Opioid</b> [2] - 21:21, 24:6 <b>opioid</b> [86] - 7:12, 7:14, 9:6, 9:14, 13:6, 15:21, 18:12, 18:19, 19:6, 20:9, 21:18, 22:15, 24:18, 25:7, 25:11, 26:1, 26:6, 27:19, 32:2, 33:20, 34:8, 34:17, 35:15, 35:20, 35:25, 37:19, 38:1, 55:17, 57:8, 58:6, 59:21, 61:22, 62:20, 63:15, 64:19, 64:23, 65:2, 65:3, 65:16, 65:22, 66:16, 68:17, 72:9, 73:9, 73:21, 73:23, 73:25, 74:2, 74:4, 76:21, 77:25, 80:1, 81:15, 81:24, 81:25, 102:13, 112:24, 113:14, 113:16, 113:17, 113:21, 113:23, 115:5, 119:23, 120:3, 120:21, 120:23, 121:5, 123:2, 123:6, 123:9, 124:8, 130:9, 130:21, 132:23, 133:9, 133:18, 133:22, 134:2, 134:4, 134:5,</p>	<p>134:13, 134:17, 135:11, 140:2 <b>opioid-related</b> [6] - 123:2, 123:6, 130:9, 133:22, 134:2, 134:13 <b>opioids</b> [127] - 7:23, 9:11, 9:19, 15:3, 15:11, 15:24, 16:12, 16:21, 18:8, 19:13, 19:24, 20:6, 20:7, 20:17, 20:19, 21:4, 21:9, 21:25, 23:19, 23:22, 24:23, 25:5, 25:19, 26:17, 26:19, 27:4, 28:20, 28:23, 29:15, 29:21, 31:14, 31:24, 32:4, 32:8, 32:12, 35:12, 35:21, 37:7, 37:9, 37:14, 55:21, 58:14, 58:16, 58:24, 59:12, 59:16, 62:20, 63:10, 63:12, 63:16, 63:18, 63:20, 65:9, 65:10, 66:23, 70:21, 71:2, 71:7, 71:8, 72:3, 72:23, 73:4, 74:9, 76:7, 76:10, 76:18, 77:19, 77:21, 78:14, 78:21, 79:3, 80:18, 82:1, 83:22, 87:8, 87:22, 88:12, 88:17, 88:25, 89:10, 89:11, 92:4, 93:7, 97:16, 97:21, 99:16, 101:6, 101:15, 101:17, 101:21, 101:23, 101:24, 102:1, 102:4, 110:16, 112:25, 113:12, 114:7, 114:20, 115:24, 115:25, 116:8, 117:24, 118:1, 118:6, 118:13, 118:19, 118:23, 118:24, 119:3, 119:7, 121:12, 121:14, 121:23, 122:16, 122:18, 130:12, 134:8, 136:11, 143:20, 144:10, 150:12 <b>Opioids</b> [1] - 16:22 <b>opium</b> [5] - 139:18, 139:20, 139:21, 139:25, 140:3 <b>opportunity</b> [4] - 54:14, 138:12,</p>	<p>138:21, 146:23 <b>option</b> [1] - 18:21 <b>orange</b> [2] - 16:3, 16:7 <b>Order</b> [13] - 12:25, 38:10, 39:25, 40:11, 42:16, 43:23, 54:19, 61:20, 104:8, 104:20, 104:25, 105:22, 106:15 <b>order</b> [45] - 8:25, 12:20, 14:9, 22:12, 40:13, 40:20, 44:22, 47:13, 50:6, 51:20, 52:12, 52:16, 56:15, 67:6, 69:2, 71:20, 75:7, 87:23, 102:19, 103:15, 103:16, 103:19, 103:21, 105:4, 106:1, 106:9, 106:10, 106:12, 107:7, 107:12, 107:13, 108:18, 108:20, 109:17, 110:1, 110:3, 111:3, 134:17, 140:17, 144:23, 146:3, 153:1 <b>ordered</b> [2] - 55:25, 56:9 <b>ordering</b> [1] - 140:21 <b>orders</b> [77] - 9:6, 9:23, 13:6, 28:16, 29:2, 29:3, 38:10, 40:21, 40:24, 41:1, 41:4, 41:18, 42:4, 42:15, 43:2, 44:25, 45:1, 45:24, 47:20, 49:19, 49:21, 49:23, 50:3, 50:4, 50:8, 50:9, 60:9, 60:13, 71:21, 71:22, 71:23, 100:9, 102:18, 102:23, 103:8, 103:9, 103:11, 103:12, 103:25, 104:1, 104:4, 104:15, 104:18, 104:21, 105:1, 105:9, 105:13, 105:15, 105:17, 105:24, 106:4, 106:18, 106:22, 106:25, 107:1, 107:2, 107:5, 107:15, 107:17, 107:22, 107:24, 108:1, 108:3, 108:8, 108:10, 108:13, 108:15, 108:23, 109:1, 109:13, 109:17, 110:8, 110:13, 111:5,</p>	<p>111:7, 111:14, 150:16 <b>organic</b> [1] - 143:1 <b>organization</b> [1] - 83:4 <b>organizations</b> [3] - 17:5, 18:15, 116:14 <b>Oriente</b> [1] - 109:9 <b>originally</b> [2] - 151:13, 151:14 <b>Orleans</b> [1] - 3:8 <b>otherwise</b> [2] - 115:15, 153:14 <b>OUR</b> [4] - 116:2, 121:25 <b>ought</b> [1] - 68:14 <b>out-of-touch</b> [1] - 127:24 <b>outbreak</b> [1] - 62:2 <b>outline</b> [1] - 40:1 <b>outpatient</b> [2] - 127:16, 127:20 <b>output</b> [3] - 148:12, 148:13, 148:14 <b>outputs</b> [1] - 148:17 <b>outside</b> [6] - 65:14, 80:17, 98:8, 98:10, 98:17, 98:21 <b>outweigh</b> [1] - 27:4 <b>over-prescribing</b> [2] - 31:10, 77:24 <b>over-supply</b> [1] - 10:4 <b>overall</b> [9] - 9:5, 33:11, 34:10, 36:19, 37:21, 52:19, 52:23, 64:17, 74:4 <b>overarching</b> [1] - 70:16 <b>overdose</b> [4] - 65:3, 132:23, 133:1, 133:9 <b>overdoses</b> [6] - 62:5, 114:11, 114:13, 132:23, 133:1, 133:9 <b>overflow</b> [1] - 14:19 <b>overheard</b> [1] - 151:11 <b>override</b> [1] - 137:23 <b>overseen</b> [1] - 125:3 <b>oversell</b> [2] - 112:5, 112:14 <b>overstate</b> [1] - 112:7 <b>overt</b> [1] - 142:12 <b>overwhelming</b> [11] - 9:8, 31:4, 32:3, 76:13, 77:1, 80:20, 80:22, 87:2, 90:13, 90:15, 136:17 <b>overwhelmingly</b> [2] - 71:1, 76:7 <b>owe</b> [1] - 150:25 <b>owed</b> [1] - 139:13 <b>own</b> [17] - 22:2, 24:13,</p>	<p>40:24, 71:4, 75:12, 92:11, 97:14, 107:16, 108:7, 110:16, 130:18, 131:11, 131:18, 131:20, 132:6, 132:12, 133:7 <b>oxycodone</b> [1] - 16:8 <b>Oxycontin</b> [1] - 16:24</p>
<b>P</b>				
<p><b>P-1200</b> [1] - 2:7 <b>P-42116</b> [1] - 52:6 <b>p.m</b> [1] - 153:22 <b>P.O</b> [2] - 5:14, 6:8 <b>PA</b> [3] - 6:6, 6:13, 6:15 <b>Page</b> [2] - 141:6, 141:9 <b>pages</b> [2] - 19:21, 52:7 <b>Pain</b> [6] - 17:7, 19:11, 19:23, 21:6, 23:4, 60:23 <b>pain</b> [67] - 9:11, 15:12, 16:21, 16:25, 17:2, 17:4, 17:16, 17:18, 17:21, 17:25, 18:5, 18:11, 18:16, 18:17, 18:20, 19:3, 19:5, 19:6, 20:4, 20:6, 20:11, 20:12, 20:24, 21:4, 21:9, 21:10, 21:11, 21:13, 23:14, 24:17, 24:23, 25:3, 25:16, 25:18, 25:19, 26:3, 32:2, 33:25, 34:16, 34:19, 35:5, 35:14, 35:20, 37:13, 59:21, 66:23, 66:24, 74:16, 80:1, 83:4, 83:20, 83:23, 87:8, 88:11, 88:16, 88:17, 89:8, 89:12, 90:5, 95:4, 95:8, 118:2, 118:6, 137:10 <b>pain-causing</b> [4] - 33:25, 34:16, 34:19, 35:5 <b>paint</b> [2] - 93:18, 94:4 <b>pan</b> [1] - 13:2 <b>panel</b> [1] - 23:25 <b>Papantonio</b> [2] - 2:10, 132:2 <b>paper</b> [9] - 78:2, 128:21, 131:11, 131:12, 131:21, 131:25, 132:1, 132:5, 135:7 <b>papers</b> [2] - 67:23, 132:9</p>				



<p><u>paradigm</u> <sup>[1]</sup> - 94:23</p> <p><u>paragraph</u> <sup>[1]</sup> - 141:19</p> <p><u>part</u> <sup>[12]</sup> - 18:1, 18:4, 22:9, 25:19, 35:2, 41:14, 44:23, 46:2, 57:15, 121:19, 140:12, 143:12</p> <p><u>participants</u> <sup>[1]</sup> - 149:24</p> <p><u>particular</u> <sup>[15]</sup> - 13:14, 23:16, 25:11, 33:24, 40:24, 52:20, 67:12, 72:21, 79:18, 79:20, 81:9, 81:12, 82:11, 96:18, 123:7</p> <p><u>particularly</u> <sup>[2]</sup> - 91:18, 102:13</p> <p><u>parties</u> <sup>[8]</sup> - 82:14, 101:21, 102:7, 117:1, 124:7, 124:21, 124:24, 137:4</p> <p><u>parties"</u> <sup>[1]</sup> - 116:24</p> <p><u>parts</u> <sup>[1]</sup> - 34:17</p> <p><u>party</u> <sup>[1]</sup> - 85:1</p> <p><u>passages</u> <sup>[1]</sup> - 84:15</p> <p><u>passed</u> <sup>[6]</sup> - 19:10, 21:6, 23:3, 24:5, 104:24, 105:2</p> <p><u>passengers</u> <sup>[1]</sup> - 149:22</p> <p><u>past</u> <sup>[6]</sup> - 64:1, 65:17, 78:11, 128:22, 138:3, 139:1</p> <p><u>pathway</u> <sup>[1]</sup> - 64:13</p> <p><u>patience</u> <sup>[1]</sup> - 152:8</p> <p><u>patient</u> <sup>[15]</sup> - 17:1, 18:6, 23:14, 27:3, 39:16, 61:2, 61:3, 61:10, 66:22, 66:25, 80:1, 80:6, 90:9</p> <p><u>patient's</u> <sup>[2]</sup> - 61:11, 78:12</p> <p><u>patient-by-patient</u> <sup>[1]</sup> - 27:3</p> <p><u>patients</u> <sup>[20]</sup> - 9:19, 11:10, 18:22, 21:9, 26:3, 28:11, 32:4, 35:20, 60:10, 60:13, 60:14, 75:9, 89:23, 90:5, 95:4, 95:6, 98:16, 98:19, 137:12, 137:15</p> <p><u>patients'</u> <sup>[2]</sup> - 28:14, 118:6</p> <p><u>pattern</u> <sup>[6]</sup> - 78:24, 92:12, 103:17, 103:21, 144:6, 145:12</p> <p><u>patterns</u> <sup>[1]</sup> - 145:10</p>	<p><u>PAUL</u> <sup>[2]</sup> - 2:3, 5:9</p> <p><u>Pause</u> <sup>[3]</sup> - 14:23, 132:19, 152:17</p> <p><u>pay</u> <sup>[6]</sup> - 122:13, 122:24, 124:2, 124:4, 124:12, 124:14</p> <p><u>payment</u> <sup>[1]</sup> - 120:23</p> <p><u>payments</u> <sup>[2]</sup> - 125:3, 125:4</p> <p><u>pays</u> <sup>[1]</sup> - 123:18</p> <p><u>PEARL</u> <sup>[1]</sup> - 3:6</p> <p><u>penalize</u> <sup>[1]</sup> - 91:7</p> <p><u>pending</u> <sup>[2]</sup> - 86:24, 141:24</p> <p><u>pendulum</u> <sup>[1]</sup> - 22:25</p> <p><u>Pensacola</u> <sup>[1]</sup> - 2:11</p> <p><u>people</u> <sup>[25]</sup> - 9:18, 23:8, 35:11, 36:11, 63:16, 63:17, 63:20, 63:22, 64:3, 64:7, 64:14, 67:2, 80:15, 80:16, 91:15, 92:22, 93:22, 121:20, 122:15, 122:21, 123:24, 127:2, 127:6, 133:1, 140:20</p> <p><u>people's</u> <sup>[1]</sup> - 71:2</p> <p><u>per</u> <sup>[16]</sup> - 14:1, 30:14, 30:15, 33:15, 33:19, 34:7, 34:9, 34:13, 34:14, 47:10, 64:23, 75:16, 75:17, 75:19, 88:2, 88:5</p> <p><u>percent</u> <sup>[35]</sup> - 9:13, 9:24, 10:1, 28:22, 31:10, 31:13, 37:2, 37:3, 37:6, 37:7, 37:8, 49:25, 50:24, 50:25, 63:7, 63:8, 63:21, 76:12, 96:4, 98:3, 101:7, 106:4, 108:5, 108:7, 112:24, 113:10, 119:6, 119:9, 132:24, 133:2, 133:9, 133:10, 133:24</p> <p><u>percentage</u> <sup>[4]</sup> - 37:24, 52:19, 52:20, 63:18</p> <p><u>perfect</u> <sup>[6]</sup> - 9:14, 10:1, 28:1, 28:17, 38:18, 147:10</p> <p><u>perfectly</u> <sup>[3]</sup> - 36:21, 70:3, 147:8</p> <p><u>perhaps</u> <sup>[7]</sup> - 23:9, 99:8, 106:20, 112:8, 124:18, 127:5, 133:16</p>	<p><u>period</u> <sup>[16]</sup> - 16:25, 41:19, 42:11, 43:8, 45:15, 46:11, 46:12, 51:23, 62:14, 88:11, 97:22, 105:18, 125:16, 142:16, 143:5, 148:3</p> <p><u>periods</u> <sup>[1]</sup> - 52:25</p> <p><u>permit</u> <sup>[2]</sup> - 91:21, 135:23</p> <p><u>permits</u> <sup>[1]</sup> - 88:3</p> <p><u>person</u> <sup>[13]</sup> - 30:14, 30:16, 45:20, 53:7, 54:14, 54:15, 75:16, 75:17, 75:19, 116:1, 116:2, 121:25, 122:17</p> <p><u>personal</u> <sup>[3]</sup> - 92:8, 92:10, 94:6</p> <p><u>Pervasive</u> <sup>[1]</sup> - 77:24</p> <p><u>perversion</u> <sup>[1]</sup> - 137:17</p> <p><u>PETER</u> <sup>[1]</sup> - 2:9</p> <p><u>pharma</u> <sup>[1]</sup> - 60:19</p> <p><u>pharmaceutical</u> <sup>[4]</sup> - 90:8, 91:4, 115:18, 116:10</p> <p><u>Pharmaceutical</u> <sup>[2]</sup> - 104:13, 139:14</p> <p><u>pharmacies</u> <sup>[26]</sup> - 11:10, 12:7, 12:8, 16:14, 28:12, 36:24, 37:3, 48:15, 48:17, 49:1, 49:2, 49:5, 91:3, 98:9, 98:12, 98:17, 98:20, 98:22, 98:24, 98:25, 99:3, 99:7, 99:12, 102:1, 102:15, 111:12</p> <p><u>Pharmacies</u> <sup>[1]</sup> - 56:8</p> <p><u>pharmacist</u> <sup>[3]</sup> - 44:6, 66:24, 144:24</p> <p><u>pharmacists</u> <sup>[2]</sup> - 45:2, 54:7</p> <p><u>pharmacy</u> <sup>[37]</sup> - 40:14, 46:15, 49:6, 49:7, 54:17, 55:24, 56:2, 56:3, 56:4, 60:4, 60:8, 61:1, 61:11, 67:7, 75:7, 78:25, 79:5, 79:8, 79:12, 79:14, 79:17, 80:18, 96:24, 97:10, 99:5, 100:6, 100:16, 100:19, 100:22, 101:4, 101:10, 109:22, 145:18, 145:20, 146:7, 146:12, 146:15</p> <p><u>Pharmacy</u> <sup>[9]</sup> - 12:16,</p>	<p>44:7, 45:6, 100:13, 100:17, 101:1, 101:3, 101:5, 102:6</p> <p><u>pharmacy-level</u> <sup>[1]</sup> - 101:10</p> <p><u>phase</u> <sup>[1]</sup> - 92:2</p> <p><u>Philadelphia</u> <sup>[2]</sup> - 6:6, 6:13</p> <p><u>phonetic</u> <sup>[1]</sup> - 151:16</p> <p><u>phonetic)</u> <sup>[1]</sup> - 39:8</p> <p><u>phrase</u> <sup>[2]</sup> - 53:5, 116:9</p> <p><u>physical</u> <sup>[1]</sup> - 35:23</p> <p><u>physically</u> <sup>[1]</sup> - 35:7</p> <p><u>physician</u> <sup>[6]</sup> - 17:8, 31:18, 81:14, 140:8, 141:15, 142:5</p> <p><u>physicians</u> <sup>[2]</sup> - 23:12, 24:3</p> <p><u>pickers</u> <sup>[1]</sup> - 40:23</p> <p><u>picking</u> <sup>[1]</sup> - 97:9</p> <p><u>piece</u> <sup>[9]</sup> - 14:12, 31:3, 31:15, 32:13, 33:23, 36:10, 44:22, 44:23, 65:13</p> <p><u>pieces</u> <sup>[1]</sup> - 29:24</p> <p><u>PIFKO</u> <sup>[1]</sup> - 3:14</p> <p><u>Pill</u> <sup>[1]</sup> - 113:3</p> <p><u>pill</u> <sup>[6]</sup> - 13:25, 30:19, 30:21, 76:19, 145:25</p> <p><u>pills</u> <sup>[71]</sup> - 14:1, 24:7, 29:23, 30:14, 30:15, 30:25, 38:2, 73:6, 73:20, 74:22, 75:7, 75:16, 75:17, 75:19, 76:3, 77:11, 78:6, 78:8, 78:15, 78:21, 78:22, 78:25, 79:7, 79:9, 79:11, 79:14, 79:17, 79:19, 79:24, 80:5, 80:7, 80:10, 80:15, 80:16, 82:18, 88:1, 88:4, 88:5, 88:7, 96:2, 96:3, 96:14, 97:8, 97:19, 97:24, 99:5, 99:18, 101:7, 101:22, 101:25, 109:20, 109:22, 110:6, 110:10, 111:11, 113:6, 114:2, 119:11, 144:5, 145:3, 145:16, 145:17, 145:20, 145:22, 146:3, 146:7, 146:11, 150:5, 150:7, 150:17</p> <p><u>pivot</u> <sup>[2]</sup> - 114:14, 114:15</p> <p><u>pizza</u> <sup>[2]</sup> - 115:14</p>	<p><u>place</u> <sup>[5]</sup> - 27:17, 45:10, 60:9, 79:25, 130:11</p> <p><u>placed</u> <sup>[1]</sup> - 95:11</p> <p><u>places</u> <sup>[2]</sup> - 8:19, 65:8</p> <p><u>plaintiff</u> <sup>[4]</sup> - 65:15, 132:1, 135:2</p> <p><u>Plaintiff</u> <sup>[5]</sup> - 1:5, 1:11, 2:2, 3:2, 4:1</p> <p><u>plaintiffs</u> <sup>[112]</sup> - 7:9, 7:20, 8:24, 9:21, 10:25, 11:19, 12:2, 12:22, 12:23, 26:23, 29:5, 29:20, 33:19, 38:9, 39:24, 45:25, 46:20, 46:23, 46:25, 48:5, 49:9, 51:10, 51:11, 51:25, 52:5, 53:4, 54:10, 54:14, 54:20, 54:25, 55:5, 55:7, 57:13, 58:11, 59:5, 59:6, 59:10, 61:15, 61:22, 62:18, 63:8, 63:14, 68:6, 68:8, 68:16, 68:24, 70:19, 71:10, 71:16, 71:19, 72:1, 72:10, 73:3, 74:10, 78:9, 78:11, 80:23, 84:6, 84:21, 85:7, 87:4, 91:23, 91:24, 92:21, 93:11, 96:1, 96:6, 96:16, 97:4, 97:12, 97:13, 98:7, 98:18, 98:21, 100:2, 102:9, 102:10, 102:17, 111:11, 111:18, 113:1, 113:13, 114:14, 116:6, 116:23, 117:5, 118:17, 118:21, 118:23, 121:1, 121:3, 121:10, 121:12, 122:3, 123:4, 124:1, 125:1, 127:3, 128:3, 128:8, 128:11, 128:21, 129:4, 132:2, 133:17, 134:20, 134:22, 135:12, 135:19, 136:6, 136:17, 138:3</p> <p><u>Plaintiffs</u> <sup>[4]</sup> - 38:5, 57:5, 67:17, 154:4</p> <p><u>plaintiffs'</u> <sup>[41]</sup> - 11:15, 22:2, 24:12, 24:15, 25:1, 25:6, 31:23, 59:10, 64:18, 66:22, 69:15, 70:14, 70:25, 71:4, 72:5, 73:2,</p>
--	--	--	--	---

75:12, 77:15, 78:13,  
86:11, 95:17, 96:19,  
98:5, 99:15, 99:24,  
101:16, 102:21,  
109:25, 111:4,  
112:22, 114:19,  
115:22, 117:13,  
118:17, 121:19,  
122:2, 122:6,  
123:20, 135:8,  
136:11, 136:14  
**Plan** [6] - 125:13,  
125:14, 125:17,  
125:22, 126:2,  
126:20  
**plan** [15] - 66:2, 66:11,  
66:16, 73:22,  
123:20, 126:4,  
126:13, 126:15,  
126:18, 127:25,  
128:22, 147:6,  
147:11, 147:15,  
152:14  
**plans** [1] - 134:1  
**plausible** [1] - 107:25  
**play** [2] - 41:20, 123:1  
**played** [2] - 26:14,  
41:22  
**players** [1] - 101:20  
**plead** [1] - 91:23  
**pleadings** [1] - 86:23  
**Pleasant** [3] - 4:4,  
4:12, 4:15  
**pleasure** [1] - 138:11  
**point** [72] - 10:17,  
13:8, 27:1, 27:22,  
27:24, 28:16, 36:17,  
43:1, 43:22, 48:7,  
53:4, 63:14, 64:17,  
65:20, 65:21, 67:21,  
70:19, 71:10, 71:15,  
71:24, 72:5, 73:21,  
74:13, 74:25, 75:4,  
75:10, 75:20, 77:14,  
77:23, 78:8, 78:9,  
78:10, 78:16, 79:17,  
81:16, 81:22, 87:21,  
90:6, 93:5, 96:18,  
97:11, 98:7, 99:8,  
100:17, 104:13,  
105:25, 107:20,  
108:11, 109:2,  
109:21, 110:24,  
111:16, 112:5,  
112:17, 113:12,  
114:9, 114:10,  
119:10, 119:17,  
122:6, 128:7,  
128:13, 128:15,  
129:16, 136:19,

137:1, 138:4,  
139:16, 140:13,  
142:3, 143:4, 145:16  
**pointed** [3] - 66:14,  
97:1, 98:12  
**pointing** [4] - 72:25,  
73:1, 73:16, 98:7  
**points** [8] - 57:13,  
63:6, 70:16, 80:19,  
89:3, 136:9, 139:9  
**poke** [1] - 147:12  
**police** [3] - 45:4,  
65:25, 115:2  
**Police** [1] - 101:8  
**policies** [4] - 17:21,  
21:15, 22:14, 104:12  
**policy** [4] - 20:4, 20:5,  
88:23, 125:6  
**politic** [1] - 139:24  
**pollution** [1] - 85:22  
**polysubstance** [2] -  
64:19, 64:24  
**Ponc** [1] - 2:4  
**Ponce** [1] - 2:14  
**poor** [1] - 66:14  
**pop** [1] - 148:3  
**Pope** [2] - 89:20,  
137:10  
**population** [2] - 27:10,  
35:4  
**populations** [2] - 34:4,  
35:13  
**portion** [1] - 27:10  
**position** [4] - 27:7,  
55:4, 95:11, 144:11  
**possibility** [1] - 96:13  
**possibly** [3] - 79:23,  
88:4, 114:18  
**post** [1] - 60:14  
**post-surgical** [1] -  
60:14  
**potential** [2] - 92:10,  
115:15  
**potentially** [1] - 94:13  
**Potomac** [1] - 148:6  
**Powell** [1] - 2:6  
**power** [1] - 67:25  
**powerful** [2] - 119:5,  
129:16  
**PR** [2] - 2:5, 2:14  
**practical** [1] - 24:2  
**practice** [12] - 31:20,  
32:9, 41:24, 47:23,  
78:5, 78:6, 82:1,  
103:25, 104:8,  
104:9, 105:2, 148:21  
**practiced** [1] - 44:8  
**practices** [3] - 27:14,  
88:20, 149:3  
**practicing** [1] - 88:22

**pre** [1] - 40:18  
**pre-2008** [3] - 40:5,  
41:5, 42:11  
**pre-determined** [1] -  
40:18  
**precise** [2] - 49:18,  
82:24  
**precisely** [3] - 82:8,  
90:24, 92:9  
**preclude** [1] - 91:7  
**predominantly** [2] -  
114:4, 121:2  
**prefer** [1] - 152:20  
**premise** [5] - 109:14,  
125:21, 130:16,  
139:22, 140:6  
**prescribe** [17] - 16:12,  
19:13, 19:24, 21:9,  
21:10, 21:25, 23:23,  
24:7, 25:19, 31:14,  
34:10, 55:20, 60:3,  
78:21, 81:15, 91:20,  
95:3  
**prescribed** [28] - 9:11,  
23:13, 31:24, 32:4,  
37:14, 38:3, 66:23,  
71:2, 71:9, 72:24,  
75:16, 75:21, 76:13,  
77:10, 77:19, 77:24,  
78:21, 79:7, 80:7,  
82:18, 89:12, 89:17,  
90:15, 91:2, 94:21,  
101:22, 141:13,  
141:16  
**prescribers** [5] -  
27:13, 31:2, 31:10,  
66:18, 77:5  
**prescribes** [1] - 80:5  
**prescribing** [105] -  
10:20, 11:10, 15:2,  
15:14, 15:21, 16:10,  
16:21, 18:7, 20:7,  
20:10, 20:16, 20:19,  
21:18, 22:3, 22:15,  
22:17, 22:23, 23:6,  
23:19, 23:22, 24:18,  
24:21, 24:23, 25:7,  
25:11, 25:13, 25:23,  
26:1, 26:6, 26:11,  
26:19, 27:14, 27:16,  
28:20, 28:22, 30:5,  
31:5, 31:10, 32:1,  
32:12, 33:20, 34:1,  
34:17, 35:16, 36:13,  
37:19, 37:20, 38:1,  
59:11, 59:16, 59:22,  
59:23, 60:7, 66:9,  
70:23, 71:12, 71:14,  
72:22, 73:12, 73:19,  
73:25, 74:21, 75:2,

75:3, 76:2, 76:6,  
76:12, 76:17, 76:23,  
77:2, 77:16, 77:24,  
78:6, 80:20, 81:10,  
81:16, 81:23, 81:25,  
83:18, 85:3, 87:3,  
88:19, 89:24, 90:17,  
90:20, 90:23, 95:7,  
95:13, 101:25,  
110:11, 111:1,  
112:25, 113:5,  
113:10, 113:15,  
114:15, 116:17,  
117:20, 118:10,  
136:10, 136:13,  
137:9, 137:15,  
137:21, 141:24  
**Prescribing** [1] -  
21:21  
**prescription** [95] - 9:5,  
13:6, 14:10, 23:9,  
25:5, 29:15, 31:18,  
32:7, 39:16, 39:17,  
44:10, 52:20, 57:8,  
58:16, 58:24, 60:8,  
62:7, 62:20, 63:9,  
63:12, 63:15, 63:16,  
63:17, 63:20, 65:2,  
65:9, 69:10, 70:21,  
72:3, 73:4, 74:9,  
74:22, 75:23, 76:9,  
76:10, 77:21, 78:14,  
78:17, 79:12, 79:20,  
79:25, 80:17, 80:18,  
82:6, 83:22, 87:8,  
87:22, 88:12, 88:17,  
89:10, 92:4, 95:1,  
97:16, 97:21, 101:6,  
101:17, 101:21,  
101:23, 101:24,  
102:1, 102:4,  
109:19, 109:23,  
110:15, 112:25,  
113:11, 113:16,  
113:17, 113:20,  
113:23, 114:7,  
114:20, 115:24,  
115:25, 116:8,  
117:7, 117:24,  
118:1, 118:6,  
118:13, 118:18,  
118:22, 118:24,  
119:3, 119:7,  
119:23, 120:3,  
121:14, 122:16,  
122:18, 136:11,  
143:20, 144:10,  
150:11  
**prescriptions** [38] -  
9:12, 12:9, 13:22,  
14:1, 14:2, 14:4,

14:14, 15:5, 16:15,  
24:8, 24:9, 28:12,  
30:12, 31:2, 31:7,  
34:7, 34:8, 34:9,  
34:13, 34:14, 37:11,  
55:18, 56:8, 59:1,  
60:10, 60:19, 69:11,  
73:24, 74:3, 74:8,  
74:14, 75:6, 75:25,  
90:13, 110:4, 110:6,  
143:17, 150:8  
**presence** [1] - 94:12  
**present** [8] - 17:19,  
40:6, 58:10, 92:11,  
97:14, 134:20,  
135:3, 138:13  
**presentation** [3] -  
34:18, 42:22, 43:24  
**presented** [10] -  
42:20, 47:1, 48:1,  
94:17, 96:9, 96:17,  
97:4, 107:23, 117:2,  
125:1  
**presents** [2] - 81:21,  
82:15  
**press** [1] - 138:24  
**pressure** [1] - 34:24  
**pretend** [1] - 139:20  
**pretrial** [2] - 136:23,  
138:4  
**pretty** [6] - 17:10,  
39:18, 50:15,  
132:11, 146:25  
**prevailing** [3] - 70:23,  
77:12, 91:9  
**prevalence** [1] - 62:16  
**prevent** [1] - 150:3  
**prevention** [2] - 66:3,  
66:11  
**prevents** [1] - 107:14  
**previous** [1] - 52:21  
**previously** [11] -  
63:12, 75:5, 75:14,  
75:24, 77:10, 85:13,  
117:9, 118:22,  
119:3, 119:6, 119:9  
**Prevoznik** [1] - 144:12  
**price** [3] - 115:9,  
115:11, 117:17  
**primarily** [1] - 100:23  
**primary** [2] - 63:14,  
140:10  
**principally** [1] - 97:12  
**principle** [1] - 125:6  
**principles** [2] -  
122:11, 124:20  
**prison** [1] - 143:18  
**private** [1] - 93:21  
**problem** [19] - 7:14,  
18:18, 49:11, 61:13,

<p>62:9, 62:12, 64:17, 64:20, 64:21, 65:16, 65:25, 68:17, 78:18, 85:10, 115:5, 119:2, 119:11, 119:18, 129:18</p> <p><b>problems</b> [4] - 55:11, 91:15, 94:16, 119:14</p> <p><b>procedure</b> [1] - 46:16</p> <p><b>procedures</b> [2] - 8:23, 45:14</p> <p><b>proceed</b> [2] - 70:11, 112:1</p> <p><b>proceeded</b> [1] - 81:14</p> <p><b>Proceedings</b> [1] - 6:19</p> <p><b>proceedings</b> [1] - 154:3</p> <p><b>PROCEEDINGS</b> [1] - 7:1</p> <p><b>process</b> [2] - 42:11, 44:13</p> <p><b>Proctor</b> [1] - 2:10</p> <p><b>produced</b> [2] - 6:19, 52:5</p> <p><b>product</b> [5] - 91:12, 92:13, 92:15, 92:20, 94:24</p> <p><b>production</b> [2] - 9:15, 88:3</p> <p><b>products</b> [16] - 90:19, 91:17, 91:21, 92:19, 93:6, 93:8, 93:16, 93:23, 94:9, 94:18, 94:20, 104:9, 112:6, 112:11, 122:21</p> <p><b>products-related</b> [1] - 93:6</p> <p><b>profession</b> [1] - 78:19</p> <p><b>professional</b> [2] - 31:20, 54:8</p> <p><b>professionals</b> [2] - 47:19, 73:19</p> <p><b>profiles</b> [1] - 52:12</p> <p><b>profound</b> [1] - 90:21</p> <p><b>Program</b> [5] - 23:4, 104:25, 126:24, 127:5</p> <p><b>program</b> [14] - 40:17, 41:6, 41:17, 42:18, 42:20, 43:18, 44:4, 46:18, 47:3, 48:1, 48:2, 48:4</p> <p><b>programs</b> [24] - 22:14, 40:12, 42:23, 44:11, 123:1, 123:3, 123:6, 123:10, 123:12, 123:24, 124:2, 124:4, 124:7, 124:11, 124:13,</p>	<p>124:16, 127:20, 128:23, 129:9, 129:14, 129:15, 130:2, 130:7, 130:13</p> <p><b>progressed</b> [1] - 114:7</p> <p><b>progression</b> [1] - 119:16</p> <p><b>projections</b> [1] - 126:21</p> <p><b>projects</b> [2] - 123:3</p> <p><b>prominent</b> [2] - 17:7, 114:3</p> <p><b>promote</b> [1] - 21:4</p> <p><b>promoted</b> [2] - 18:16, 101:25</p> <p><b>prone</b> [1] - 64:7</p> <p><b>prong</b> [2] - 55:7, 66:3</p> <p><b>pronounce</b> [2] - 39:8, 39:10</p> <p><b>proof</b> [6] - 11:3, 11:14, 59:24, 109:10, 133:20, 134:12</p> <p><b>proper</b> [3] - 92:9, 121:16, 128:5</p> <p><b>properly</b> [4] - 87:23, 99:17, 128:11, 135:19</p> <p><b>proposal</b> [1] - 125:8</p> <p><b>proposed</b> [5] - 57:12, 135:15, 147:14, 152:10, 153:1</p> <p><b>proposition</b> [3] - 56:21, 68:10</p> <p><b>prospective</b> [1] - 113:13</p> <p><b>prospects</b> [1] - 112:7</p> <p><b>protect</b> [1] - 20:15</p> <p><b>prove</b> [9] - 12:2, 54:25, 55:10, 57:1, 58:11, 58:19, 69:4, 69:6, 72:11</p> <p><b>proven</b> [6] - 55:5, 56:24, 61:15, 69:2, 69:3, 136:6</p> <p><b>proves</b> [3] - 11:17, 66:7, 102:18</p> <p><b>provide</b> [6] - 13:13, 90:4, 110:25, 123:23, 124:7, 134:22</p> <p><b>provided</b> [4] - 35:3, 129:7, 131:19, 144:14</p> <p><b>providers</b> [3] - 17:17, 35:18, 35:19</p> <p><b>provides</b> [1] - 18:21</p> <p><b>providing</b> [2] - 124:8, 141:12</p> <p><b>proximate</b> [47] - 55:4, 57:3, 57:4, 57:10,</p>	<p>58:3, 58:21, 66:19, 67:9, 67:12, 67:19, 70:20, 71:9, 72:2, 72:15, 72:21, 80:24, 81:3, 81:11, 82:3, 82:12, 82:22, 83:10, 83:15, 83:16, 83:25, 84:4, 84:7, 84:9, 84:11, 84:16, 85:4, 85:9, 86:9, 86:11, 86:16, 114:18, 116:20, 117:6, 117:10, 118:12, 118:14, 120:10, 120:12, 136:18, 136:25, 137:3, 151:1</p> <p><b>prudent</b> [1] - 96:25</p> <p><b>public</b> [47] - 71:11, 72:12, 87:4, 87:6, 89:15, 89:18, 89:19, 89:22, 89:25, 90:2, 90:11, 90:22, 90:25, 91:2, 91:5, 91:6, 91:10, 91:15, 91:16, 91:24, 91:25, 92:5, 92:7, 92:9, 92:15, 93:15, 93:20, 93:24, 93:25, 94:5, 94:8, 94:17, 95:14, 103:1, 103:2, 107:9, 110:23, 112:17, 137:7, 137:8, 137:11, 137:14, 137:17, 137:20, 137:22, 137:23, 138:5</p> <p><b>publicly</b> [1] - 28:22</p> <p><b>published</b> [2] - 29:14, 35:10</p> <p><b>pull</b> [2] - 17:11, 17:12</p> <p><b>Purchase</b> [2] - 41:13, 41:23</p> <p><b>purchase</b> [2] - 40:19, 52:23</p> <p><b>purchases</b> [1] - 40:18</p> <p><b>Purdue</b> [2] - 16:24, 59:21</p> <p><b>pure</b> [1] - 115:10</p> <p><b>purity</b> [2] - 115:10, 117:17</p> <p><b>purpose</b> [9] - 24:1, 31:19, 47:20, 94:23, 100:15, 116:1, 121:8, 134:11, 145:2</p> <p><b>purpose</b> [1] - 76:11</p> <p><b>purposes</b> [4] - 31:14, 57:2, 106:20, 107:23</p> <p><b>pursuant</b> [1] - 29:2</p> <p><b>pursue</b> [1] - 68:24</p> <p><b>pushing</b> [1] - 59:21</p>	<p><b>put</b> [28] - 7:9, 10:25, 14:12, 16:2, 17:13, 19:2, 21:13, 26:23, 27:7, 27:20, 27:24, 46:24, 47:11, 47:17, 80:19, 85:16, 89:3, 89:21, 97:20, 116:22, 121:22, 125:7, 125:17, 130:11, 132:16, 132:20, 146:19, 147:15</p> <p><b>putting</b> [5] - 86:3, 97:15, 97:18, 98:4, 132:25</p> <p><b>puzzled</b> [1] - 97:6</p>	<p><b>R</b></p> <p><b>Rafalski</b> [33] - 8:21, 11:8, 14:8, 30:23, 31:12, 31:13, 49:10, 49:17, 49:18, 51:5, 51:15, 56:1, 61:9, 74:5, 76:11, 77:3, 77:4, 79:15, 97:1, 100:5, 103:20, 105:25, 107:11, 107:15, 108:22, 109:2, 109:9, 109:16, 110:12, 145:6, 146:17</p> <p><b>Rafalski's</b> [10] - 9:24, 11:5, 30:24, 50:23, 50:25, 96:22, 108:12, 109:15, 145:8, 146:2</p> <p><b>Rafferty</b> [1] - 2:10</p> <p><b>rain</b> [1] - 148:14</p> <p><b>raise</b> [2] - 36:12, 46:4</p> <p><b>raised</b> [4] - 28:5, 55:15, 91:11, 105:2</p> <p><b>raises</b> [1] - 128:17</p> <p><b>raising</b> [1] - 28:25</p> <p><b>Randolph</b> [2] - 148:7, 148:13</p> <p><b>random</b> [1] - 51:2</p> <p><b>range</b> [3] - 37:6, 94:3, 108:4</p> <p><b>ranked</b> [2] - 34:21, 34:25</p> <p><b>ranks</b> [1] - 34:6</p> <p><b>Rannazzisi</b> [21] - 8:2, 9:13, 9:17, 10:6, 10:14, 27:12, 28:7, 31:9, 75:10, 76:11, 77:4, 77:5, 79:15, 80:8, 90:6, 90:25, 99:1, 100:8, 104:3, 106:3, 107:6</p> <p><b>Rannazzisi's</b> [1] - 8:3</p> <p><b>rapid</b> [1] - 73:23</p> <p><b>rarely</b> [1] - 93:23</p> <p><b>rate</b> [2] - 32:21, 33:13</p> <p><b>rates</b> [12] - 33:25, 34:1, 34:16, 34:19, 35:14, 36:7, 36:13, 37:19, 37:25, 65:10, 73:25</p> <p><b>rather</b> [6] - 7:15, 70:1, 73:2, 92:7, 119:1, 132:5</p> <p><b>rating</b> [1] - 36:5</p> <p><b>ratio</b> [2] - 36:19, 36:21</p> <p><b>raw</b> [1] - 29:21</p> <p><b>re</b> [3] - 21:12, 45:9, 151:10</p>
--	--	---	---	--

<p><b>re-adopted</b> [1] - 21:12</p> <p><b>re-examine</b> [1] - 45:9</p> <p><b>re-told</b> [1] - 151:10</p> <p><b>reach</b> [2] - 120:15, 136:5</p> <p><b>reached</b> [1] - 104:22</p> <p><b>read</b> [6] - 19:17, 25:8, 68:6, 140:5, 142:10, 142:15</p> <p><b>reading</b> [1] - 141:10</p> <p><b>ready</b> [5] - 7:7, 14:24, 111:19, 138:19, 138:25</p> <p><b>real</b> [7] - 15:4, 26:3, 50:16, 64:20, 112:16, 127:12, 143:22</p> <p><b>realistically</b> [1] - 121:13</p> <p><b>reality</b> [3] - 63:22, 127:9, 128:16</p> <p><b>really</b> [2] - 113:4, 130:15</p> <p><b>Reardon</b> [4] - 40:8, 43:7, 43:9, 43:14</p> <p><b>Reardon's</b> [1] - 40:10</p> <p><b>reason</b> [11] - 18:3, 22:3, 29:1, 29:3, 39:15, 67:9, 67:11, 76:1, 128:14, 144:4, 150:12</p> <p><b>reasonable</b> [8] - 8:8, 12:4, 14:7, 15:15, 22:20, 26:10, 32:16, 37:10</p> <p><b>reasonableness</b> [5] - 11:25, 58:21, 75:25, 76:1, 76:5</p> <p><b>reasonably</b> [1] - 22:17</p> <p><b>reasoning</b> [3] - 86:12, 94:2, 94:16</p> <p><b>reasons</b> [7] - 29:10, 36:1, 70:20, 85:11, 103:19, 138:5, 145:14</p> <p><b>reboot</b> [1] - 14:19</p> <p><b>receive</b> [1] - 122:25</p> <p><b>received</b> [2] - 34:12, 105:23</p> <p><b>receiving</b> [3] - 28:17, 123:13, 124:24</p> <p><b>recent</b> [3] - 106:6, 113:5, 115:17</p> <p><b>recently</b> [1] - 85:18</p> <p><b>recess</b> [2] - 38:20, 111:24</p> <p><b>Recess</b> [3] - 38:22, 70:10, 111:25</p> <p><b>reckoning</b> [1] - 152:7</p> <p><b>recognition</b> [2] -</p>	<p>62:15, 143:5</p> <p><b>recognized</b> [5] - 36:23, 94:5, 94:16, 136:15, 151:20</p> <p><b>recommendation</b> [1] - 66:12</p> <p><b>recommendations</b> [2] - 25:13, 66:17</p> <p><b>recommended</b> [2] - 23:21, 89:11</p> <p><b>record</b> [48] - 42:7, 47:8, 52:6, 52:22, 62:10, 63:4, 65:23, 70:15, 71:9, 71:11, 72:10, 77:20, 79:11, 81:21, 82:15, 84:3, 84:4, 87:6, 87:7, 89:15, 92:2, 92:4, 95:4, 95:9, 96:15, 100:20, 102:11, 103:18, 106:7, 108:25, 109:24, 111:7, 113:22, 114:21, 123:20, 123:22, 124:6, 124:9, 125:9, 128:25, 136:1, 136:24, 138:4, 139:5, 144:12, 154:3</p> <p><b>recorded</b> [1] - 6:19</p> <p><b>records</b> [2] - 109:6, 109:7</p> <p><b>recover</b> [2] - 128:9, 135:13</p> <p><b>recovery</b> [1] - 130:4</p> <p><b>red</b> [1] - 98:11</p> <p><b>redress</b> [1] - 130:21</p> <p><b>reduce</b> [3] - 74:16, 132:23, 133:1</p> <p><b>reduced</b> [1] - 115:9</p> <p><b>reduction</b> [1] - 133:8</p> <p><b>Reduction</b> [1] - 24:6</p> <p><b>Reed</b> [2] - 6:4, 6:11</p> <p><b>reference</b> [3] - 31:9, 45:25, 51:13</p> <p><b>referred</b> [7] - 43:18, 74:15, 81:18, 82:12, 82:13, 84:14, 115:3</p> <p><b>referring</b> [1] - 78:5</p> <p><b>reflect</b> [2] - 10:23, 98:11</p> <p><b>reflected</b> [13] - 27:18, 81:3, 92:17, 104:5, 105:16, 105:20, 108:21, 109:8, 113:8, 114:9, 115:12, 123:7, 126:19</p> <p><b>reflecting</b> [3] - 108:18, 119:6, 119:10</p>	<p><b>reflects</b> [17] - 72:21, 90:24, 101:2, 104:14, 105:21, 106:17, 110:16, 112:8, 114:22, 117:12, 119:1, 125:11, 127:14, 127:15, 128:13, 128:16, 133:7</p> <p><b>refusing</b> [1] - 95:12</p> <p><b>Register</b> [1] - 31:17</p> <p><b>registered</b> [1] - 144:24</p> <p><b>registration</b> [1] - 143:25</p> <p><b>regular</b> [2] - 45:3, 47:24</p> <p><b>regularly</b> [1] - 46:8</p> <p><b>regulate</b> [2] - 140:17, 145:3</p> <p><b>regulated</b> [2] - 61:2, 139:22</p> <p><b>regulation</b> [2] - 42:3, 103:14</p> <p><b>Regulations</b> [1] - 149:25</p> <p><b>regulator</b> [2] - 103:3, 103:5</p> <p><b>regulators</b> [3] - 89:4, 89:15, 91:20</p> <p><b>regulatory</b> [8] - 45:18, 103:15, 118:9, 137:24, 142:22, 143:3, 144:13, 150:10</p> <p><b>reject</b> [2] - 84:20, 120:9</p> <p><b>rejected</b> [4] - 44:21, 56:16, 67:11, 144:25</p> <p><b>related</b> [21] - 13:21, 35:8, 40:1, 48:12, 67:13, 93:6, 98:24, 105:4, 105:8, 108:3, 112:23, 113:20, 120:21, 120:24, 123:2, 123:6, 130:9, 133:22, 134:2, 134:13, 135:17</p> <p><b>relates</b> [6] - 31:3, 36:17, 58:3, 58:4, 62:13, 100:21</p> <p><b>relating</b> [1] - 71:19</p> <p><b>relation</b> [2] - 81:5, 117:2</p> <p><b>relationship</b> [2] - 65:7, 72:16</p> <p><b>relative</b> [1] - 36:7</p> <p><b>release</b> [1] - 52:16</p> <p><b>relevant</b> [1] - 13:25</p> <p><b>reliability</b> [1] - 128:18</p> <p><b>reliable</b> [1] - 132:14</p>	<p><b>relied</b> [1] - 102:9</p> <p><b>relief</b> [8] - 11:18, 18:16, 18:21, 67:25, 72:7, 113:13, 135:3, 135:4</p> <p><b>relieve</b> [1] - 17:18</p> <p><b>rely</b> [3] - 99:17, 116:24, 132:7</p> <p><b>relying</b> [1] - 113:17</p> <p><b>remains</b> [1] - 54:17</p> <p><b>remarkable</b> [2] - 30:22, 139:11</p> <p><b>remarkably</b> [1] - 108:4</p> <p><b>remedy</b> [24] - 68:1, 72:6, 72:12, 106:23, 120:17, 120:19, 120:20, 120:22, 121:3, 121:12, 121:16, 121:19, 122:2, 122:15, 122:20, 122:23, 123:12, 134:21, 134:24, 135:10, 135:15, 135:23, 136:1, 136:5</p> <p><b>remember</b> [5] - 16:4, 39:2, 39:6, 60:16, 93:11</p> <p><b>remembering</b> [1] - 59:4</p> <p><b>remind</b> [3] - 29:11, 31:11, 51:17</p> <p><b>reminded</b> [2] - 38:24, 39:12</p> <p><b>remote</b> [5] - 57:18, 58:6, 61:21, 63:3, 116:22</p> <p><b>remoteness</b> [6] - 84:9, 84:14, 84:17, 84:20, 84:23, 117:9</p> <p><b>remove</b> [2] - 21:7, 98:2</p> <p><b>removed</b> [2] - 83:8, 83:12</p> <p><b>renders</b> [1] - 130:18</p> <p><b>renew</b> [1] - 22:12</p> <p><b>rep</b> [1] - 99:24</p> <p><b>repeatedly</b> [3] - 54:9, 96:1, 110:15</p> <p><b>replies</b> [3] - 152:22, 153:3, 153:5</p> <p><b>Report</b> [1] - 106:7</p> <p><b>report</b> [22] - 22:8, 40:20, 50:6, 52:16, 53:18, 62:2, 62:4, 65:18, 65:19, 65:25, 66:8, 66:13, 102:17, 102:22, 106:22, 111:4, 115:12, 129:2, 130:19</p>	<p><b>reported</b> [15] - 36:4, 41:2, 41:18, 50:4, 102:24, 103:25, 104:18, 105:8, 106:18, 106:19, 108:2, 110:9, 111:8, 111:16, 154:7</p> <p><b>Reporter</b> [6] - 6:17, 6:18, 154:1, 154:10</p> <p><b>reporting</b> [15] - 40:13, 71:20, 102:19, 105:1, 105:5, 105:12, 105:17, 106:9, 106:10, 106:12, 110:1, 110:3, 110:12, 111:3</p> <p><b>reports</b> [11] - 34:12, 40:15, 41:14, 42:1, 45:8, 56:18, 56:20, 62:3, 65:19, 65:22, 66:17</p> <p><b>Reports</b> [10] - 40:16, 40:17, 41:12, 41:13, 41:23, 104:8, 104:20, 105:22, 106:15, 140:9</p> <p><b>representative</b> [2] - 54:3, 54:12</p> <p><b>represented</b> [1] - 101:7</p> <p><b>representing</b> [1] - 132:2</p> <p><b>represents</b> [3] - 132:3, 133:24</p> <p><b>reprinted</b> [1] - 21:1</p> <p><b>requested</b> [3] - 72:6, 105:1, 135:25</p> <p><b>require</b> [1] - 74:15</p> <p><b>required</b> [7] - 18:5, 22:11, 23:6, 23:14, 27:13, 27:14, 122:7</p> <p><b>requirement</b> [4] - 72:16, 86:8, 104:15, 109:6</p> <p><b>requirements</b> [2] - 110:18, 114:19</p> <p><b>research</b> [1] - 64:6</p> <p><b>residue</b> [2] - 86:3</p> <p><b>Resiliency</b> [6] - 125:13, 125:17, 125:22, 126:2, 126:20</p> <p><b>resolution</b> [1] - 92:25</p> <p><b>resolve</b> [3] - 111:2, 120:8, 120:14</p> <p><b>resolved</b> [1] - 93:13</p> <p><b>resources</b> [5] - 68:20, 125:15, 129:17, 129:21, 132:25</p> <p><b>respect</b> [5] - 54:19,</p>
--	---	--	---	--



<p>57:11, 67:22, 144:7, 144:10</p> <p><u>respectfully</u> [2] - 141:21, 143:24</p> <p><u>respond</u> [2] - 18:7, 90:16</p> <p><u>responded</u> [3] - 15:12, 18:6, 74:20</p> <p><u>responding</u> [2] - 75:23, 76:4</p> <p><u>responds</u> [1] - 75:4</p> <p><u>response</u> [12] - 42:18, 66:16, 68:8, 68:22, 73:22, 87:3, 91:7, 104:24, 106:8, 109:2, 145:21, 145:22</p> <p><u>responsibilities</u> [1] - 150:10</p> <p><u>responsibility</u> [4] - 42:8, 61:10, 88:6, 144:9</p> <p><u>Responsible</u> [1] - 21:21</p> <p><u>responsible</u> [4] - 71:3, 136:16, 150:1, 150:11</p> <p><u>rest</u> [2] - 23:18, 118:21</p> <p><u>Restatement</u> [4] - 89:21, 92:18, 93:14, 137:13</p> <p><u>restricted</u> [1] - 35:19</p> <p><u>restrictions</u> [1] - 26:1</p> <p><u>result</u> [5] - 74:10, 78:4, 116:12, 122:8, 122:14</p> <p><u>resulted</u> [3] - 22:14, 77:24, 136:12</p> <p><u>resulting</u> [1] - 144:16</p> <p><u>results</u> [1] - 51:6</p> <p><u>retail</u> [1] - 96:24</p> <p><u>retention</u> [1] - 109:7</p> <p><u>retort</u> [1] - 138:21</p> <p><u>retrospect</u> [1] - 26:6</p> <p><u>return</u> [1] - 136:8</p> <p><u>revamping</u> [1] - 43:22</p> <p><u>review</u> [3] - 8:23, 47:20, 48:13</p> <p><u>reviewed</u> [4] - 45:21, 53:15, 53:17, 104:24</p> <p><u>reviewing</u> [2] - 100:17, 108:10</p> <p><u>reviews</u> [1] - 52:14</p> <p><u>revised</u> [1] - 152:10</p> <p><u>Rhode</u> [2] - 93:19, 131:7</p> <p><u>rhododendron</u> [1] - 147:25</p> <p><u>Rice</u> [5] - 4:3, 4:5, 4:8, 4:11, 4:14</p>	<p><u>right-hand</u> [2] - 96:23, 108:21</p> <p><u>rights</u> [1] - 93:21</p> <p><u>rise</u> [5] - 71:23, 73:23, 121:8, 121:17, 137:5</p> <p><u>risk</u> [2] - 27:11, 87:13</p> <p><u>risks</u> [10] - 25:10, 26:17, 27:4, 87:9, 87:15, 91:17, 91:19, 95:2, 138:2</p> <p><u>risky</u> [1] - 90:21</p> <p><u>Rite</u> [2] - 100:13, 100:17</p> <p><u>River</u> [1] - 147:25</p> <p><u>RMR</u> [2] - 6:17, 6:18</p> <p><u>road</u> [1] - 151:9</p> <p><u>roadmap</u> [1] - 11:22</p> <p><u>ROBERT</u> [1] - 6:11</p> <p><u>ROBERTSON</u> [1] - 3:6</p> <p><u>rocks</u> [1] - 148:25</p> <p><u>role</u> [7] - 16:13, 26:14, 73:12, 83:18, 102:8, 123:1, 143:14</p> <p><u>roles</u> [1] - 44:9</p> <p><u>rolls</u> [1] - 51:2</p> <p><u>room</u> [1] - 14:19</p> <p><u>rose</u> [3] - 16:9, 25:7, 33:6</p> <p><u>roughly</u> [2] - 127:1, 134:8</p> <p><u>RPR</u> [1] - 6:18</p> <p><u>RPR-RMR-CRR-FCRR</u> [1] - 6:18</p> <p><u>RUBY</u> [1] - 4:22</p> <p><u>Ruby</u> [1] - 4:23</p> <p><u>rude</u> [1] - 89:20</p> <p><u>Rufus</u> [3] - 123:4, 127:22, 128:6</p> <p><u>rule</u> [3] - 68:1, 68:7, 85:19</p> <p><u>Rule</u> [6] - 91:11, 92:6, 120:17, 125:8, 152:23, 153:3</p> <p><u>run</u> [4] - 44:7, 46:18, 124:2, 127:4</p> <p><u>running</u> [4] - 123:10, 124:16, 133:23, 133:25</p> <p><u>rural</u> [2] - 35:11, 35:13</p> <p><u>rush</u> [1] - 14:21</p>	<p>140:6, 145:1</p> <p><u>sales</u> [3] - 54:3, 99:24, 100:3</p> <p><u>SALGADO</u> [1] - 4:20</p> <p><u>San</u> [2] - 2:5, 2:14</p> <p><u>sanctioned</u> [3] - 144:15, 144:17</p> <p><u>sat</u> [1] - 10:18</p> <p><u>saves</u> [1] - 85:9</p> <p><u>saw</u> [7] - 16:25, 18:6, 22:22, 28:18, 28:21, 29:11, 87:13</p> <p><u>SC</u> [3] - 4:4, 4:12, 4:15</p> <p><u>scale</u> [1] - 74:16</p> <p><u>scatter</u> [1] - 65:4</p> <p><u>SCHMIDT</u> [1] - 5:9</p> <p><u>school</u> [2] - 60:22, 139:8</p> <p><u>School</u> [1] - 15:19</p> <p><u>science</u> [2] - 131:23, 131:24</p> <p><u>scientific</u> [1] - 132:8</p> <p><u>scope</u> [4] - 122:1, 122:19, 129:1, 142:4</p> <p><u>scorecard</u> [1] - 139:8</p> <p><u>screen</u> [1] - 50:15</p> <p><u>Script</u> [1] - 100:21</p> <p><u>se</u> [3] - 64:23, 88:2, 88:5</p> <p><u>second</u> [2] - 9:23, 19:14, 31:3, 44:22, 70:25, 71:10, 71:13, 77:1, 77:5, 77:14, 77:17, 90:23, 95:12, 105:3, 105:16, 118:16, 137:3, 137:16, 144:16, 144:17</p> <p><u>Second</u> [1] - 63:17</p> <p><u>second-guess</u> [5] - 71:13, 77:1, 77:5, 90:23, 137:16</p> <p><u>second-guessed</u> [1] - 9:23</p> <p><u>second-guessing</u> [1] - 95:12</p> <p><u>Secretary</u> [1] - 24:20</p> <p><u>section</u> [1] - 45:18</p> <p><u>see</u> [42] - 8:12, 16:9, 23:12, 24:8, 25:21, 30:8, 35:15, 42:23, 49:22, 60:8, 70:8, 84:13, 92:17, 93:17, 97:9, 104:5, 104:13, 104:17, 106:6, 112:21, 113:5, 113:7, 114:12, 126:19, 126:21, 127:9, 127:10, 127:12, 129:24,</p>	<p>133:22, 141:9, 145:15, 145:23, 146:11, 148:14, 150:2, 151:13, 151:20, 152:1, 152:25, 153:20</p> <p><u>seeing</u> [4] - 28:19, 80:3, 112:19, 119:18</p> <p><u>seek</u> [3] - 11:19, 88:23, 134:10</p> <p><u>seeking</u> [6] - 93:6, 120:23, 121:1, 121:12, 121:14, 135:2</p> <p><u>seeks</u> [1] - 106:23</p> <p><u>seized</u> [1] - 101:8</p> <p><u>sell</u> [3] - 142:13, 143:19, 145:20</p> <p><u>seller</u> [1] - 142:5</p> <p><u>selling</u> [3] - 140:16, 142:6, 145:24</p> <p><u>sells</u> [3] - 61:3, 61:5, 80:6</p> <p><u>seminal</u> [1] - 23:20</p> <p><u>SEMP</u> [2] - 23:25, 24:1</p> <p><u>SENIOR</u> [1] - 1:17</p> <p><u>senior</u> [1] - 47:19</p> <p><u>Senior</u> [1] - 7:2</p> <p><u>Sensabaugh</u> [1] - 5:14</p> <p><u>sense</u> [6] - 16:13, 28:1, 28:17, 107:8, 129:15, 146:3</p> <p><u>sent</u> [7] - 21:25, 22:6, 40:15, 43:9, 56:18, 56:20, 60:16</p> <p><u>sentence</u> [2] - 131:12, 131:13</p> <p><u>separate</u> [1] - 86:9</p> <p><u>separately</u> [1] - 85:24</p> <p><u>September</u> [7] - 42:21, 43:3, 43:7, 43:13, 43:24, 44:14, 126:10</p> <p><u>sequence</u> [1] - 115:24</p> <p><u>series</u> [1] - 51:1</p> <p><u>serious</u> [2] - 18:17, 87:13</p> <p><u>serve</u> [2] - 11:22, 127:1</p> <p><u>served</u> [5] - 12:15, 49:3, 98:9, 100:22, 102:15</p> <p><u>serves</u> [1] - 99:25</p> <p><u>service</u> [1] - 90:3</p> <p><u>Services</u> [3] - 126:23, 126:24, 127:4</p> <p><u>services</u> [2] - 122:25, 129:6</p> <p><u>serving</u> [1] - 127:5</p> <p><u>set</u> [11] - 12:12, 28:4, 43:22, 44:24, 45:8,</p>	<p>45:23, 76:2, 82:23, 86:14, 136:21, 138:17</p> <p><u>sets</u> [2] - 28:2, 88:2</p> <p><u>setting</u> [4] - 43:15, 43:19, 46:3, 46:15</p> <p><u>Settlement</u> [3] - 48:8, 105:3, 105:7</p> <p><u>settlement</u> [5] - 49:8, 104:22, 105:10, 105:16, 105:20</p> <p><u>seven</u> [1] - 43:12</p> <p><u>several</u> [17] - 23:16, 36:15, 42:9, 45:2, 48:1, 52:11, 74:14, 85:8, 85:12, 85:15, 86:5, 86:7, 86:10, 114:16, 139:1, 153:14</p> <p><u>severe</u> [2] - 21:9, 21:11</p> <p><u>SHANNON</u> [1] - 6:3</p> <p><u>Shapiro</u> [2] - 60:21</p> <p><u>share</u> [4] - 98:2, 99:13, 99:20, 151:11</p> <p><u>shelf</u> [2] - 79:12, 109:18</p> <p><u>Sheriff</u> [3] - 114:2, 114:24, 130:3</p> <p><u>shift</u> [5] - 22:25, 23:1, 39:23, 54:24, 57:3</p> <p><u>shifted</u> [2] - 113:23, 113:24</p> <p><u>shifting</u> [1] - 20:1</p> <p><u>shifts</u> [2] - 78:5</p> <p><u>ship</u> [6] - 43:2, 91:1, 95:13, 104:9, 104:15, 146:7</p> <p><u>shipment</u> [3] - 75:18, 75:19, 88:3</p> <p><u>shipments</u> [31] - 26:9, 36:20, 37:3, 37:9, 48:15, 48:17, 51:2, 65:9, 71:15, 73:7, 76:2, 87:3, 90:16, 95:22, 95:24, 96:6, 96:7, 96:8, 96:10, 96:11, 96:17, 97:3, 97:15, 98:3, 98:8, 99:12, 99:14, 102:25, 103:4, 103:5, 113:16</p> <p><u>shipped</u> [29] - 9:1, 9:6, 12:21, 13:6, 29:15, 29:21, 29:23, 29:25, 30:25, 32:15, 36:22, 40:21, 41:3, 41:18, 48:20, 48:23, 56:10, 69:3, 69:5, 73:4, 75:21, 90:14, 97:18,</p>
--	---	--	--	---

<p>97:23, 99:5, 107:6, 111:8, 111:15 <b>shipping</b> [2] - 27:9, 42:15 <b>shocking</b> [5] - 108:6, 116:10, 122:10, 127:8, 131:18 <b>shockingly</b> [1] - 126:16 <b>Shope</b> [11] - 51:13, 52:1, 52:3, 52:5, 52:8, 53:8, 53:20, 54:5, 54:6, 54:12, 54:16 <b>shopping</b> [1] - 23:7 <b>short</b> [5] - 99:11, 112:2, 118:12, 120:2, 134:20 <b>show</b> [11] - 17:12, 33:9, 38:9, 43:6, 47:23, 55:7, 57:5, 62:23, 65:2, 86:8, 150:22 <b>showed</b> [7] - 27:22, 30:4, 33:5, 34:19, 63:24, 65:4, 75:19 <b>showing</b> [5] - 83:14, 124:22, 133:17, 134:19, 136:24 <b>shown</b> [6] - 26:22, 52:14, 52:15, 56:15, 124:11, 138:10 <b>shows</b> [14] - 8:7, 9:12, 11:15, 27:20, 32:24, 33:1, 33:2, 33:17, 56:19, 64:6, 109:25, 112:24, 128:2, 131:17 <b>shut</b> [1] - 101:4 <b>shy</b> [1] - 20:7 <b>side</b> [7] - 31:23, 96:23, 108:21, 114:5, 116:7, 125:7, 152:22 <b>sides</b> [5] - 14:15, 14:16, 14:17, 15:1, 99:20 <b>sides'</b> [1] - 15:8 <b>sign</b> [10] - 17:1, 17:17, 17:25, 18:11, 24:17, 25:20, 59:22, 60:23, 83:5, 83:20 <b>significance</b> [1] - 151:12 <b>significant</b> [8] - 18:21, 34:2, 61:14, 76:20, 113:9, 113:12, 115:5, 143:5 <b>significantly</b> [1] - 133:16 <b>signs</b> [1] - 54:4</p>	<p><b>silent</b> [2] - 96:16, 124:9 <b>similar</b> [3] - 40:12, 86:1, 86:2 <b>similarly</b> [2] - 104:14, 127:19 <b>simple</b> [1] - 119:11 <b>simpler</b> [1] - 120:10 <b>simply</b> [6] - 27:9, 64:7, 116:6, 128:16, 128:24, 135:25 <b>SIMULTANEOUS</b> [1] - 153:21 <b>Singer</b> [1] - 28:8 <b>SINGER</b> [1] - 4:8 <b>single</b> [11] - 8:25, 18:5, 26:15, 31:20, 46:6, 50:5, 56:1, 56:15, 76:22, 139:7 <b>sit</b> [2] - 109:18, 139:2 <b>site</b> [5] - 45:4, 47:24, 51:22, 53:13, 53:20 <b>sits</b> [1] - 28:16 <b>sitting</b> [2] - 67:24, 134:23 <b>situation</b> [2] - 96:13, 146:13 <b>six</b> [3] - 50:19, 98:3, 107:23 <b>sixth</b> [3] - 97:16, 100:22, 141:23 <b>size</b> [4] - 51:3, 103:16, 103:19, 103:21 <b>Skinner</b> [1] - 70:5 <b>skyrocket</b> [2] - 59:13, 59:16 <b>slide</b> [16] - 30:8, 32:23, 47:11, 81:4, 82:7, 85:16, 88:21, 97:20, 98:11, 98:19, 108:21, 116:23, 121:4, 147:20, 148:9 <b>slides</b> [1] - 19:17 <b>small</b> [3] - 99:13, 99:14, 99:20 <b>smaller</b> [1] - 133:25 <b>smarter</b> [1] - 38:24 <b>Smith</b> [2] - 6:4, 6:11 <b>Smith's</b> [1] - 114:9 <b>Smithfield</b> [2] - 91:11, 94:19 <b>social</b> [2] - 64:21, 125:6 <b>Social</b> [1] - 66:5 <b>Society</b> [2] - 17:7, 18:16 <b>sold</b> [8] - 67:2, 73:20, 77:22, 80:11, 115:13, 140:7, 144:5, 145:18</p>	<p><b>sole</b> [1] - 149:3 <b>solely</b> [3] - 84:7, 107:22, 113:13 <b>Solutions</b> [3] - 68:18, 130:7, 130:11 <b>Someone</b> [1] - 61:4 <b>someone</b> [8] - 46:17, 60:5, 60:6, 61:6, 67:1, 114:25, 132:7 <b>sometimes</b> [1] - 55:6 <b>SOMS</b> [1] - 48:6 <b>Sonner</b> [2] - 68:2, 68:7 <b>sorry</b> [5] - 14:18, 14:20, 39:19, 79:15, 132:18 <b>sort</b> [5] - 48:11, 92:16, 125:14, 129:20, 135:23 <b>sought</b> [3] - 133:15, 135:10, 135:24 <b>souls</b> [2] - 151:21, 151:25 <b>source</b> [2] - 63:14, 79:24 <b>South</b> [2] - 2:11, 140:20 <b>south</b> [2] - 148:5, 148:6 <b>SOUTHERN</b> [1] - 1:1 <b>Southern</b> [1] - 7:3 <b>Southwood</b> [1] - 104:16 <b>sovereign</b> [1] - 68:11 <b>span</b> [1] - 37:25 <b>SPEAKERS</b> [1] - 153:21 <b>speaking</b> [1] - 109:7 <b>Speaking</b> [1] - 27:17 <b>speaks</b> [1] - 137:6 <b>special</b> [2] - 23:15, 51:7 <b>specialist</b> [1] - 64:11 <b>specific</b> [9] - 9:2, 12:20, 39:3, 46:17, 49:1, 49:2, 87:9, 87:13, 104:19 <b>specifically</b> [2] - 29:25, 57:8 <b>specifics</b> [1] - 48:7 <b>spectrum</b> [1] - 146:16 <b>spend</b> [5] - 39:24, 47:6, 51:10, 51:14, 123:5 <b>spending</b> [1] - 133:21 <b>spent</b> [1] - 7:10 <b>spike</b> [1] - 114:12 <b>split</b> [1] - 70:1 <b>spot</b> [1] - 23:7 <b>Square</b> [2] - 6:5, 6:12 <b>stack</b> [1] - 65:19</p>	<p><b>staff</b> [2] - 106:11, 106:15 <b>stake</b> [3] - 73:3, 102:8, 113:1 <b>stale</b> [1] - 98:24 <b>stamp</b> [2] - 140:19, 141:14 <b>stand</b> [9] - 18:9, 44:15, 46:23, 48:21, 54:16, 107:24, 118:19, 146:20, 151:2 <b>standard</b> [44] - 9:9, 9:10, 15:11, 15:22, 16:10, 16:11, 16:16, 16:19, 18:13, 20:2, 22:18, 22:21, 22:24, 24:10, 24:12, 24:22, 25:3, 26:5, 26:10, 26:13, 27:18, 28:5, 29:2, 29:7, 37:12, 41:24, 43:15, 43:19, 45:14, 57:4, 59:5, 59:7, 59:19, 69:12, 74:12, 76:24, 80:25, 82:1, 84:20, 84:23, 104:7, 137:10, 141:10, 141:25 <b>standards</b> [8] - 18:1, 18:4, 22:21, 70:23, 77:12, 88:14, 90:2, 91:9 <b>standing</b> [6] - 54:17, 73:7, 85:2, 149:13, 149:14, 149:23 <b>STANNER</b> [1] - 5:10 <b>start</b> [7] - 11:25, 20:1, 57:4, 58:20, 69:24, 72:15, 123:10 <b>started</b> [4] - 12:23, 17:20, 32:22, 33:17 <b>starting</b> [3] - 15:23, 104:17, 114:13 <b>starts</b> [1] - 23:1 <b>State</b> [11] - 19:2, 19:9, 29:20, 54:17, 68:12, 69:13, 93:17, 110:14, 110:19, 110:21, 110:24 <b>state</b> [18] - 12:8, 12:10, 20:20, 21:2, 22:15, 24:21, 44:7, 44:8, 44:10, 47:25, 60:2, 60:4, 65:15, 84:24, 103:3, 103:5, 134:7, 145:24 <b>state's</b> [1] - 15:21 <b>State's</b> [1] - 110:16 <b>statement</b> [15] - 18:14, 18:16, 19:3, 19:10, 20:4, 20:5, 20:10, 20:11, 21:13, 82:7, 90:10, 96:22, 103:23, 117:8, 123:8 <b>statements</b> [2] - 36:25, 88:23 <b>STATES</b> [2] - 1:1, 1:17 <b>States</b> [17] - 7:2, 18:18, 31:18, 68:11, 87:20, 87:24, 88:8, 104:6, 140:6, 140:9, 141:3, 141:14, 141:21, 142:10, 142:12, 143:5, 149:25 <b>states</b> [5] - 22:6, 35:8, 35:16, 35:24, 85:18 <b>statewide</b> [1] - 33:22 <b>statistics</b> [1] - 37:21 <b>STATUS</b> [1] - 1:17 <b>Status</b> [1] - 7:2 <b>statute</b> [1] - 85:14 <b>stayed</b> [2] - 46:7, 47:9 <b>staying</b> [1] - 35:20 <b>steadfastly</b> [1] - 144:8 <b>steals</b> [1] - 61:4 <b>stenography</b> [1] - 6:19 <b>Stephanie</b> [2] - 64:22, 129:13 <b>stepping</b> [1] - 28:15 <b>steps</b> [1] - 11:9 <b>Steve</b> [2] - 32:10, 40:8 <b>STEVEN</b> [1] - 4:22 <b>still</b> [5] - 25:25, 47:10, 47:12, 93:1, 127:7 <b>stolen</b> [2] - 80:11, 115:25 <b>stood</b> [1] - 148:25 <b>stop</b> [4] - 27:8, 41:4, 61:8, 146:4 <b>stopped</b> [1] - 41:1 <b>story</b> [5] - 151:8, 151:10, 151:13, 151:14 <b>straight</b> [3] - 63:4, 112:11, 148:4 <b>strategic</b> [2] - 66:2, 66:11 <b>stream</b> [2] - 85:22, 86:3 <b>Street</b> [15] - 2:7, 2:11, 3:5, 3:7, 3:10, 3:12, 4:6, 4:9, 4:19, 4:21, 4:24, 5:5, 5:12, 6:6, 6:13 <b>street</b> [1] - 151:17 <b>strict</b> [1] - 26:2 <b>strike</b> [1] - 26:21 <b>striking</b> [1] - 24:10 <b>string</b> [1] - 62:5</p>
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<p><b>stripped</b> <sup>[1]</sup> - 126:12</p> <p><b>stronger</b> <sup>[1]</sup> - 24:5</p> <p><b>struggled</b> <sup>[1]</sup> - 103:13</p> <p><b>studied</b> <sup>[1]</sup> - 65:18</p> <p><b>study</b> <sup>[5]</sup> - 63:11, 63:13, 63:24, 119:5, 119:8</p> <p><b>stuff</b> <sup>[2]</sup> - 18:23, 114:5</p> <p><b>stunning</b> <sup>[3]</sup> - 129:20, 132:11, 132:12</p> <p><b>subject</b> <sup>[7]</sup> - 12:12, 12:17, 92:24, 102:16, 111:19, 112:20, 122:12</p> <p><b>submission</b> <sup>[2]</sup> - 41:11, 41:23</p> <p><b>submissions</b> <sup>[1]</sup> - 153:20</p> <p><b>submit</b> <sup>[5]</sup> - 90:1, 110:23, 152:10, 153:5</p> <p><b>submitted</b> <sup>[5]</sup> - 130:20, 131:2, 131:3, 131:8, 131:10</p> <p><b>Subparagraph</b> <sup>[2]</sup> - 139:19</p> <p><b>subpoena</b> <sup>[1]</sup> - 54:11</p> <p><b>subsequent</b> <sup>[5]</sup> - 72:3, 82:20, 86:17, 108:15, 118:14</p> <p><b>subsequently</b> <sup>[1]</sup> - 116:3</p> <p><b>substance</b> <sup>[14]</sup> - 23:14, 52:19, 62:17, 64:9, 64:24, 68:22, 77:7, 119:2, 119:11, 119:14, 119:15, 119:18, 139:18, 139:23</p> <p><b>substances</b> <sup>[9]</sup> - 36:20, 36:22, 37:2, 37:23, 64:12, 64:15, 90:9, 91:4, 142:19</p> <p><b>Substances</b> <sup>[2]</sup> - 23:3, 42:2</p> <p><b>substantial</b> <sup>[4]</sup> - 99:15, 102:12, 137:2, 150:24</p> <p><b>subtle</b> <sup>[7]</sup> - 148:13, 148:15, 148:17, 148:20, 149:2, 149:7, 150:2</p> <p><b>subtract</b> <sup>[1]</sup> - 129:6</p> <p><b>suburban</b> <sup>[1]</sup> - 115:15</p> <p><b>success</b> <sup>[2]</sup> - 132:22, 133:7</p> <p><b>successes</b> <sup>[1]</sup> - 130:12</p> <p><b>successful</b> <sup>[1]</sup> - 68:18</p> <p><b>sued</b> <sup>[2]</sup> - 18:2, 18:10</p>	<p><b>suffer</b> <sup>[1]</sup> - 35:4</p> <p><b>suffered</b> <sup>[2]</sup> - 66:22, 151:21</p> <p><b>suffering</b> <sup>[3]</sup> - 64:23, 151:23, 151:25</p> <p><b>sufficient</b> <sup>[6]</sup> - 73:8, 105:14, 134:21, 134:23, 135:1, 135:20</p> <p><b>sufficiently</b> <sup>[1]</sup> - 105:8</p> <p><b>suffuse</b> <sup>[1]</sup> - 93:3</p> <p><b>suggest</b> <sup>[6]</sup> - 83:9, 95:10, 107:15, 122:12, 124:20, 137:17</p> <p><b>suggested</b> <sup>[3]</sup> - 39:1, 84:21, 128:4</p> <p><b>suggesting</b> <sup>[2]</sup> - 85:8, 116:6</p> <p><b>suggestion</b> <sup>[2]</sup> - 122:17, 124:1</p> <p><b>suggests</b> <sup>[1]</sup> - 142:16</p> <p><b>Suite</b> <sup>[9]</sup> - 2:4, 2:7, 2:10, 2:13, 3:15, 4:6, 4:9, 6:5, 6:12</p> <p><b>sulfate</b> <sup>[4]</sup> - 140:7, 140:16, 140:23, 141:13</p> <p><b>sum</b> <sup>[3]</sup> - 37:12, 66:19, 102:11</p> <p><b>summaries</b> <sup>[1]</sup> - 96:21</p> <p><b>summarize</b> <sup>[2]</sup> - 70:17, 120:20</p> <p><b>summarized</b> <sup>[1]</sup> - 84:4</p> <p><b>summary</b> <sup>[2]</sup> - 38:4, 43:11</p> <p><b>summed</b> <sup>[2]</sup> - 50:15, 119:19</p> <p><b>Summersville</b> <sup>[1]</sup> - 149:19</p> <p><b>sums</b> <sup>[1]</sup> - 147:11</p> <p><b>Sunday</b> <sup>[1]</sup> - 68:5</p> <p><b>supervise</b> <sup>[1]</sup> - 44:3</p> <p><b>supervised</b> <sup>[2]</sup> - 124:4, 124:19</p> <p><b>supplied</b> <sup>[3]</sup> - 101:3, 101:5, 102:6</p> <p><b>supplies</b> <sup>[1]</sup> - 61:11</p> <p><b>supply</b> <sup>[26]</sup> - 10:4, 10:7, 10:16, 10:21, 39:1, 61:2, 74:4, 75:5, 75:11, 76:21, 79:3, 90:8, 115:11, 116:4, 117:18, 120:1, 137:14, 139:16, 139:20, 140:2, 140:12, 143:23, 143:24, 144:2, 144:9</p> <p><b>supplying</b> <sup>[1]</sup> - 89:16</p>	<p><b>support</b> <sup>[10]</sup> - 9:2, 72:7, 89:22, 90:4, 93:24, 102:11, 124:10, 124:16, 134:13, 135:3</p> <p><b>supported</b> <sup>[1]</sup> - 120:4</p> <p><b>supporting</b> <sup>[1]</sup> - 72:6</p> <p><b>supports</b> <sup>[2]</sup> - 26:24, 27:2</p> <p><b>supposed</b> <sup>[6]</sup> - 80:5, 80:9, 80:10, 120:2, 150:2, 150:3</p> <p><b>Supreme</b> <sup>[9]</sup> - 85:17, 85:23, 93:20, 140:6, 141:3, 141:14, 141:21, 142:10, 142:13</p> <p><b>surely</b> <sup>[2]</sup> - 120:5, 138:3</p> <p><b>surgery</b> <sup>[2]</sup> - 16:23, 97:7</p> <p><b>surgical</b> <sup>[1]</sup> - 60:14</p> <p><b>surplus</b> <sup>[4]</sup> - 133:23, 133:25, 134:2, 134:5</p> <p><b>surprise</b> <sup>[1]</sup> - 64:14</p> <p><b>surprisingly</b> <sup>[1]</sup> - 73:14</p> <p><b>suspicious</b> <sup>[55]</sup> - 8:25, 40:13, 41:4, 41:18, 42:4, 42:15, 43:2, 45:24, 49:22, 50:3, 50:5, 52:16, 71:20, 71:22, 102:18, 102:19, 102:22, 103:12, 103:15, 103:25, 104:4, 104:15, 104:18, 104:21, 105:1, 105:4, 105:9, 105:13, 105:17, 105:23, 106:1, 106:4, 106:9, 106:10, 106:12, 106:18, 106:22, 107:2, 107:17, 107:22, 107:24, 108:8, 108:15, 108:19, 108:23, 109:17, 109:18, 110:1, 110:3, 110:13, 111:3, 111:5, 111:16, 150:17, 150:18</p> <p><b>Suspicious</b> <sup>[13]</sup> - 12:25, 38:10, 39:25, 40:11, 42:16, 43:23, 54:19, 61:20, 104:8, 104:19, 104:24, 105:22, 106:15</p> <p><b>SUZANNE</b> <sup>[1]</sup> - 4:20</p>	<p><b>swallow</b> <sup>[2]</sup> - 137:20, 137:23</p> <p><b>swing</b> <sup>[1]</sup> - 128:15</p> <p><b>switch</b> <sup>[1]</sup> - 56:3</p> <p><b>Syringe</b> <sup>[3]</sup> - 126:23, 126:24, 127:4</p> <p><b>system</b> <sup>[27]</sup> - 40:2, 40:7, 41:6, 41:15, 43:4, 44:16, 44:24, 45:11, 45:21, 46:3, 47:7, 47:9, 48:6, 79:10, 80:17, 118:9, 143:2, 143:3, 143:11, 143:12, 143:14, 143:21, 145:2, 146:8, 146:18, 151:4</p> <p><b>System</b> <sup>[4]</sup> - 40:11, 43:23, 54:20, 79:9</p> <p><b>systematically</b> <sup>[1]</sup> - 109:1</p> <p><b>systemic</b> <sup>[1]</sup> - 48:11</p> <p><b>Systems</b> <sup>[5]</sup> - 12:25, 38:10, 39:25, 42:16, 61:21</p> <p><b>systems</b> <sup>[5]</sup> - 8:23, 38:9, 39:24, 40:1, 50:21</p>	<p>121:22, 151:9, 151:17, 151:18, 151:21</p> <p><b>ten-fold</b> <sup>[2]</sup> - 33:10, 33:12</p> <p><b>tends</b> <sup>[1]</sup> - 35:4</p> <p><b>Tenth</b> <sup>[1]</sup> - 5:12</p> <p><b>term</b> <sup>[1]</sup> - 61:23</p> <p><b>terminal</b> <sup>[1]</sup> - 60:13</p> <p><b>terminated</b> <sup>[1]</sup> - 49:5</p> <p><b>terms</b> <sup>[4]</sup> - 10:4, 30:19, 72:11, 132:12</p> <p><b>test</b> <sup>[5]</sup> - 57:6, 82:8, 84:11, 116:22, 131:17</p> <p><b>testified</b> <sup>[39]</sup> - 7:22, 8:7, 9:13, 10:16, 14:14, 15:14, 15:22, 17:24, 18:10, 21:8, 22:16, 24:20, 25:16, 26:15, 26:18, 27:12, 29:13, 32:7, 34:5, 34:15, 39:12, 40:4, 41:11, 41:21, 42:10, 45:14, 45:17, 50:24, 51:19, 54:3, 63:19, 76:16, 76:19, 98:15, 104:3, 127:4, 134:1, 134:9, 144:12</p> <p><b>testify</b> <sup>[4]</sup> - 20:25, 46:21, 46:22, 51:18</p> <p><b>testifying</b> <sup>[1]</sup> - 36:9</p> <p><b>testimony</b> <sup>[35]</sup> - 8:3, 8:6, 9:25, 14:12, 14:16, 15:7, 26:22, 27:2, 30:24, 33:9, 36:4, 38:25, 39:18, 42:7, 49:13, 49:14, 51:17, 62:8, 64:3, 68:19, 82:7, 87:11, 88:13, 88:21, 104:10, 104:11, 107:20, 109:8, 110:12, 113:8, 123:4, 125:12, 145:8, 146:2</p> <p><b>testing</b> <sup>[4]</sup> - 131:1, 131:6, 131:8, 131:16</p> <p><b>tethered</b> <sup>[2]</sup> - 11:19, 13:12</p> <p><b>Texas</b> <sup>[1]</sup> - 48:18</p> <p><b>THE</b> <sup>[52]</sup> - 1:1, 1:1, 1:4, 1:17, 7:6, 10:8, 10:11, 13:8, 14:18, 14:24, 19:19, 38:12, 38:16, 38:20, 39:4, 39:7, 39:21, 69:22, 70:5, 70:11, 70:13, 86:17, 86:21, 87:1, 92:21, 93:9, 96:12,</p>
---	--	--	---	--

# I

**tablets** <sup>[3]</sup> - 140:17,  
140:21, 140:23

**Tactical** <sup>[1]</sup> - 47:18

**tail** <sup>[1]</sup> - 148:6

**takeaway** <sup>[1]</sup> - 41:5

**talisman** <sup>[1]</sup> - 99:17

**tasked** <sup>[1]</sup> - 26:5

**Tate** <sup>[2]</sup> - 140:21,  
140:25

**team** <sup>[6]</sup> - 44:5, 45:2,  
45:7, 45:20, 52:13,  
53:17

**teamed** <sup>[1]</sup> - 59:20

**Teamsters** <sup>[12]</sup> -  
57:21, 67:13, 81:1,  
81:18, 82:10, 82:23,  
84:20, 86:13, 86:19,  
86:25, 136:19, 137:2

**TEDS** <sup>[2]</sup> - 127:13,  
127:15

**teenager** <sup>[1]</sup> - 121:24

**TEMITOPE** <sup>[1]</sup> - 4:13

**temperature** <sup>[1]</sup> -  
148:16

**temperatures** <sup>[1]</sup> -  
51:1

**Ten** <sup>[2]</sup> - 7:22, 151:14

**ten** <sup>[9]</sup> - 33:10, 33:12,  
83:6, 111:24,

<p>97:6, 111:21, 111:24, 112:1, 138:14, 138:16, 138:19, 138:22, 138:24, 140:14, 142:4, 142:20, 142:22, 143:8, 146:12, 146:19, 146:25, 147:23, 148:8, 152:9, 152:15, 152:18, 153:7, 153:10, 153:17 <b>themselves</b> [1] - 136:14 <b>theory</b> [27] - 58:12, 58:13, 62:19, 63:6, 65:11, 66:21, 66:22, 91:10, 93:2, 94:25, 95:6, 97:14, 98:5, 99:18, 102:21, 109:25, 110:2, 110:4, 114:17, 114:19, 115:22, 117:13, 118:17, 118:21, 120:2, 136:11 <b>therapy</b> [1] - 35:24 <b>thereafter</b> [1] - 85:5 <b>therefore</b> [5] - 33:20, 34:1, 58:15, 72:13, 128:5 <b>They've</b> [1] - 61:23 <b>they've</b> [7] - 28:5, 29:6, 52:2, 65:18, 79:5, 135:22 <b>thin</b> [2] - 120:5 <b>thinking</b> [2] - 59:4, 118:10 <b>Third</b> [2] - 63:22, 92:17 <b>third</b> [7] - 71:15, 82:14, 85:1, 116:24, 117:1, 124:7, 137:4 <b>third-party</b> [1] - 85:1 <b>Thirteen</b> [1] - 7:21 <b>Thomas</b> [1] - 2:10 <b>thoughtful</b> [1] - 93:19 <b>thousands</b> [1] - 93:10 <b>threaten</b> [1] - 94:14 <b>Three</b> [1] - 6:5 <b>three</b> [25] - 6:12, 7:13, 7:25, 8:1, 8:11, 14:6, 29:15, 35:1, 40:3, 44:15, 50:13, 78:17, 79:22, 81:16, 99:25, 102:3, 103:2, 133:4, 139:11, 140:22, 144:19, 152:19, 152:20, 153:5</p>	<p><b>three-digit</b> [2] - 29:15, 103:2 <b>threshold</b> [12] - 44:23, 44:25, 46:3, 46:15, 51:20, 52:13, 52:21, 67:22, 67:24, 108:13, 108:16, 108:20 <b>thresholds</b> [4] - 45:8, 45:9, 45:23, 46:1 <b>throughout</b> [4] - 13:5, 24:11, 138:11, 139:11 <b>throw</b> [2] - 63:8, 135:19 <b>tick</b> [1] - 136:3 <b>tie</b> [1] - 11:6 <b>tied</b> [3] - 11:21, 14:10, 121:13 <b>ties</b> [1] - 110:23 <b>tight</b> [1] - 19:22 <b>Tim</b> [1] - 15:18 <b>timeline</b> [4] - 16:18, 17:15, 22:24, 27:20 <b>TIMOTHY</b> [1] - 5:9 <b>tiny</b> [1] - 67:2 <b>tobacco</b> [1] - 119:15 <b>today</b> [19] - 13:17, 25:25, 54:16, 75:14, 75:24, 89:9, 89:12, 114:11, 123:1, 123:5, 124:2, 133:22, 141:20, 143:3, 144:19, 145:7, 152:19, 153:4, 153:5 <b>today's</b> [2] - 113:14 <b>Todd</b> [1] - 46:17 <b>together</b> [5] - 10:2, 47:17, 75:8, 80:19, 89:3 <b>took</b> [5] - 24:4, 44:12, 49:4, 106:1, 115:7 <b>tool</b> [1] - 17:17 <b>top</b> [2] - 33:2, 149:13 <b>topic</b> [3] - 43:20, 112:4, 120:16 <b>toppled</b> [1] - 140:1 <b>tort</b> [7] - 81:2, 84:21, 94:11, 122:12, 124:20, 125:6, 137:21 <b>tortfeasors</b> [1] - 85:19 <b>Torts</b> [1] - 92:18 <b>total</b> [7] - 7:20, 34:7, 34:9, 37:10, 69:15, 123:2, 125:11 <b>totally</b> [2] - 11:6, 139:21 <b>touch</b> [2] - 46:7,</p>	<p>127:24 <b>toward</b> [2] - 42:14, 114:5 <b>towards</b> [1] - 23:18 <b>Tower</b> [2] - 3:4, 4:23 <b>town</b> [2] - 140:20, 148:4 <b>track</b> [1] - 52:22 <b>tracked</b> [1] - 16:16 <b>trade</b> [1] - 115:16 <b>trafficked</b> [1] - 101:23 <b>traffickers</b> [3] - 61:17, 62:10, 116:4 <b>trafficking</b> [1] - 98:23 <b>tragic</b> [1] - 152:6 <b>training</b> [1] - 132:10 <b>transcript</b> [2] - 6:19, 154:2 <b>transition</b> [4] - 43:8, 63:18, 64:4, 119:24 <b>translate</b> [1] - 24:2 <b>translated</b> [1] - 151:15 <b>treat</b> [14] - 9:11, 15:12, 17:3, 17:21, 18:19, 21:4, 24:23, 25:18, 71:12, 83:23, 88:17, 95:3, 95:7, 137:15 <b>treated</b> [5] - 17:1, 19:3, 25:4, 25:17, 153:18 <b>treating</b> [7] - 19:4, 20:11, 20:12, 88:11, 88:16, 89:8, 89:12 <b>treatment</b> [39] - 17:21, 18:17, 18:21, 20:12, 20:23, 35:20, 68:21, 80:1, 87:8, 93:6, 116:18, 118:1, 120:21, 120:23, 121:2, 121:5, 121:16, 123:9, 123:10, 123:12, 123:17, 123:19, 123:24, 124:13, 125:19, 126:2, 126:4, 126:16, 127:10, 127:12, 127:15, 127:16, 127:19, 127:25, 128:5, 128:9, 129:14, 137:9 <b>treatments</b> [1] - 81:15 <b>tremendous</b> [1] - 130:2 <b>trend</b> [6] - 15:24, 15:25, 27:25, 28:1, 33:14, 65:5 <b>trial</b> [27] - 7:18, 8:24, 10:19, 11:3, 11:12, 12:20, 13:5, 15:8,</p>	<p>18:9, 22:7, 24:11, 27:22, 29:11, 29:24, 31:4, 42:14, 43:1, 44:3, 47:2, 51:24, 53:7, 53:15, 58:9, 58:11, 127:13, 129:12, 138:11 <b>TRIAL</b> [1] - 1:16 <b>Trial</b> [1] - 153:22 <b>tried</b> [4] - 11:6, 51:10, 52:2, 62:18 <b>trigger</b> [1] - 146:9 <b>triggered</b> [2] - 106:4, 146:10 <b>trouble</b> [2] - 20:16, 20:18 <b>trucks</b> [1] - 144:1 <b>true</b> [5] - 32:6, 36:9, 91:18, 128:24, 144:22 <b>truly</b> [1] - 152:4 <b>trust</b> [3] - 124:4, 124:19, 134:15 <b>try</b> [3] - 50:1, 117:5, 145:3 <b>trying</b> [4] - 24:22, 27:7, 139:8, 146:17 <b>turn</b> [12] - 29:24, 72:9, 72:14, 77:14, 91:6, 95:14, 102:16, 111:19, 112:20, 112:21, 120:16, 149:20 <b>turned</b> [2] - 130:4, 149:19 <b>turning</b> [1] - 61:13 <b>Twelfth</b> [3] - 4:19, 4:21, 5:5 <b>twenty</b> [1] - 100:22 <b>twenty-sixth</b> [1] - 100:22 <b>twice</b> [2] - 144:15, 144:17 <b>two</b> [35] - 8:6, 10:1, 14:15, 14:16, 14:17, 15:1, 15:17, 19:12, 20:1, 23:5, 30:18, 34:25, 48:13, 49:5, 53:5, 55:3, 70:20, 73:14, 80:19, 81:1, 85:10, 86:14, 88:14, 96:19, 98:12, 108:17, 109:7, 132:1, 132:4, 133:3, 136:9, 139:23, 152:19, 153:4 <b>two-word</b> [1] - 53:5 <b>type</b> [6] - 18:24, 52:14, 52:17, 53:1, 54:21, 146:8</p>	<p><b>types</b> [3] - 47:14, 53:1, 53:2 <b>typically</b> [1] - 132:9</p> <p style="text-align: center;"><b>U</b></p> <p><b>ultimately</b> [14] - 12:3, 14:10, 16:5, 17:15, 18:2, 24:8, 36:1, 46:24, 47:8, 54:13, 58:17, 59:6, 59:18, 147:5 <b>unaware</b> [1] - 131:25 <b>uncertain</b> [2] - 119:24, 123:21 <b>uncontroverted</b> [2] - 9:8, 89:13 <b>undefined</b> [1] - 94:12 <b>under</b> [31] - 17:21, 18:17, 19:3, 20:11, 20:12, 25:17, 40:10, 49:21, 52:25, 54:11, 63:3, 77:11, 81:2, 81:11, 82:22, 84:10, 84:18, 86:11, 89:18, 89:21, 90:1, 91:8, 116:21, 117:11, 117:13, 118:15, 120:15, 137:10, 137:13, 140:18, 149:16 <b>under-treated</b> [2] - 19:3, 25:17 <b>under-treating</b> [2] - 20:11, 20:12 <b>under-treatment</b> [2] - 17:21, 18:17 <b>underlined</b> [1] - 100:16 <b>underlying</b> [1] - 16:3 <b>undermine</b> [1] - 132:13 <b>undermines</b> [2] - 109:14, 130:16 <b>underscore</b> [2] - 87:5, 110:2 <b>understood</b> [1] - 41:6 <b>undertake</b> [1] - 129:23 <b>underway</b> [2] - 128:20, 130:8 <b>undisputed</b> [4] - 12:6, 73:18, 80:20, 80:21 <b>unduly</b> [1] - 116:22 <b>unexplained</b> [1] - 53:4 <b>Unfortunately</b> [2] - 60:18 <b>unfortunately</b> [2] - 36:5, 39:11 <b>unilaterally</b> [1] - 27:8 <b>uninterrupted</b> [1] -</p>
--	--	---	---	---



<p>90:8  <u>unique</u> [1] - 92:11  <u>Unit</u> [1] - 114:4  <u>United</u> [17] - 7:2,  18:18, 31:18, 68:11,  87:20, 87:24, 88:8,  104:5, 140:6, 140:9,  141:3, 141:14,  141:21, 142:10,  142:12, 143:5,  149:25  <u>UNITED</u> [2] - 1:1, 1:17  <u>University</u> [2] - 15:20,  74:24  <u>unlawful</u> [1] - 95:23  <u>unless</u> [2] - 81:14,  109:19  <u>unlike</u> [1] - 102:14  <u>unmet</u> [1] - 134:12  <u>unmoored</u> [1] -  124:19  <u>unnecessarily</u> [1] -  81:15  <u>unpack</u> [1] - 29:10  <u>unpleasant</u> [1] -  153:14  <u>unrealistic</u> [1] -  127:23  <u>unreasonable</u> [17] -  7:16, 11:16, 12:3,  12:22, 12:24, 13:7,  13:9, 38:7, 48:12,  88:2, 88:5, 89:24,  103:6, 122:23,  136:2, 136:4, 137:14  <u>unreasonableness</u> [2]  - 49:16, 69:14  <u>unreasonably</u> [1] -  54:22  <u>unreliability</u> [2] -  132:16, 132:20  <u>unreliable</u> [4] -  125:11, 128:2,  130:19, 132:14  <u>unseen</u> [1] - 115:10  <u>unsound</u> [1] - 132:15  <u>unspecified</u> [1] -  126:3  <u>unstable</u> [1] - 123:21  <u>unsupported</u> [4] -  11:6, 49:15, 70:15,  136:1  <u>unused</u> [9] - 77:20,  77:24, 78:6, 78:8,  78:14, 78:22, 79:24,  125:5, 134:7  <u>unusual</u> [7] - 103:16,  103:21, 144:5,  145:10, 145:11,  145:12, 147:4</p>	<p><u>unusually</u> [2] - 35:22,  37:23  <u>unworkable</u> [1] -  95:10  <u>up</u> [57] - 8:12, 9:25,  13:25, 14:4, 14:9,  14:12, 16:2, 17:12,  22:4, 22:23, 27:20,  27:24, 30:6, 30:19,  30:21, 31:1, 33:2,  33:15, 37:12, 43:19,  45:8, 45:16, 46:24,  47:11, 50:15, 50:17,  50:19, 53:13, 57:25,  58:1, 60:14, 66:19,  73:17, 74:7, 85:16,  97:9, 97:20, 102:11,  107:16, 111:13,  116:23, 118:19,  119:19, 123:19,  125:24, 126:1,  126:7, 126:16,  126:23, 138:17,  141:22, 147:11,  147:20, 148:2,  149:13, 149:14  <u>up-to-date</u> [1] - 45:16  <u>updated</u> [1] - 45:21  <u>Upper</u> [2] - 148:24,  148:25  <u>upper</u> [1] - 59:1  <u>ups</u> [1] - 130:24  <u>upside</u> [1] - 91:6  <u>upstairs</u> [1] - 142:1  <u>upstream</u> [1] - 28:21  <u>urged</u> [3] - 25:18,  88:10, 88:12  <u>urges</u> [1] - 21:24  <u>users</u> [8] - 11:11,  63:12, 63:25,  118:22, 119:2,  119:6, 119:9, 119:13  <u>uses</u> [3] - 61:5, 80:15,  91:13  <u>usual</u> [1] - 31:19  <u>utter</u> [2] - 106:7,  128:19  <u>utterly</u> [2] - 61:21,  126:17</p>	<p><u>value</u> [1] - 77:25  <u>valve</u> [5] - 146:9,  146:10, 149:17,  150:1  <u>vantage</u> [1] - 28:16  <u>variables</u> [4] - 130:23,  131:5, 131:9, 131:14  <u>variety</u> [3] - 46:10,  53:3, 63:25  <u>various</u> [3] - 47:14,  116:24, 130:8  <u>vary</u> [1] - 103:19  <u>vast</u> [11] - 22:19,  31:23, 32:11, 63:19,  67:14, 68:15, 76:16,  81:18, 122:25,  123:13, 123:19  <u>vastly</u> [1] - 113:5  <u>vehicle</u> [1] - 93:15  <u>Ventura</u> [1] - 3:15  <u>verbatim</u> [1] - 145:25  <u>verdict</u> [2] - 72:18,  98:9  <u>version</u> [3] - 126:4,  126:11, 151:11  <u>versus</u> [1] - 128:6  <u>via</u> [1] - 67:4  <u>Video</u> [1] - 42:5  <u>video</u> [2] - 14:19,  41:22  <u>view</u> [7] - 10:19, 11:1,  26:7, 49:10, 57:24,  81:24, 94:23  <u>viewed</u> [3] - 42:1,  42:3, 42:10  <u>views</u> [1] - 51:5  <u>violation</u> [2] - 93:24,  144:13  <u>Virginia</u> [81] - 4:24,  7:3, 7:4, 12:14,  15:20, 15:25, 16:8,  18:24, 19:1, 19:10,  20:2, 20:3, 20:17,  21:3, 21:4, 21:23,  22:1, 22:4, 22:5,  22:25, 23:2, 23:17,  23:24, 24:3, 24:4,  24:5, 27:21, 29:20,  32:19, 33:1, 33:7,  33:11, 33:16, 33:24,  34:6, 34:9, 34:15,  34:21, 35:3, 35:16,  35:22, 37:14, 37:18,  48:10, 54:18, 57:17,  62:2, 68:12, 69:13,  73:24, 81:2, 81:11,  84:8, 84:10, 84:18,  84:21, 84:22, 84:24,  85:14, 85:17, 85:23,  88:15, 88:18, 88:20,</p>	<p>88:22, 89:18,  100:13, 110:14,  110:22, 117:8,  117:11, 118:3,  118:5, 123:16,  137:25, 144:4,  148:5, 148:22,  150:18  <u>VIRGINIA</u> [2] - 1:1,  1:18  <u>Virginia's</u> [2] - 34:19,  110:20  <u>Virginian</u> [2] - 34:12,  74:17  <u>Virginians</u> [1] - 35:6  <u>virtually</u> [4] - 31:7,  91:17, 135:10,  135:15  <u>visit</u> [2] - 53:21, 53:24  <u>visited</u> [1] - 98:16  <u>visits</u> [3] - 45:4, 47:24,  53:20  <u>vital</u> [12] - 17:1, 17:16,  17:25, 18:11, 24:17,  25:20, 59:22, 60:23,  83:5, 83:20, 90:7,  95:4  <u>Volume</u> [1] - 47:18  <u>VOLUME</u> [1] - 1:16  <u>volume</u> [65] - 9:5, 9:6,  9:9, 10:21, 13:3,  13:4, 13:6, 13:11,  13:12, 13:14, 29:6,  29:8, 29:14, 29:21,  29:25, 32:14, 32:15,  36:17, 37:12, 38:6,  38:8, 52:20, 58:14,  58:20, 58:24, 58:25,  70:21, 71:7, 73:3,  73:7, 73:20, 74:2,  74:9, 75:9, 78:11,  80:21, 87:22, 88:1,  88:4, 88:5, 88:7,  98:3, 98:5, 99:20,  101:17, 101:20,  101:22, 102:4,  111:6, 111:11,  111:17, 112:25,  113:11, 114:20,  121:11, 121:14,  140:5, 140:7,  142:17, 144:5,  149:15, 149:18,  150:11  <u>volumes</u> [10] - 99:16,  102:8, 102:9,  102:25, 113:5,  113:7, 113:17,  113:21, 136:10  <u>vs</u> [1] - 154:4</p>	<p><b>W</b>  <u>wait</u> [3] - 14:21,  141:12, 153:20  <u>waiting</u> [2] - 46:22,  129:22  <u>waived</u> [3] - 121:3,  128:11, 135:12  <u>WAKEFIELD</u> [1] - 5:13  <u>walk</u> [3] - 16:18,  66:19, 66:20  <u>walking</u> [2] - 151:9,  151:17  <u>Waller</u> [3] - 25:1, 32:1,  64:11  <u>wants</u> [1] - 70:4  <u>warned</u> [1] - 144:14  <u>warnings</u> [2] - 87:9,  87:12  <u>warranted</u> [1] - 81:17  <u>Washington</u> [8] - 4:7,  4:10, 4:19, 4:21, 5:5,  5:12, 48:19, 131:3  <u>watch</u> [4] - 22:11,  148:13, 148:14,  150:15  <u>watched</u> [1] - 149:1  <u>watching</u> [1] - 149:23  <u>water</u> [9] - 98:6,  148:16, 149:1,  149:7, 149:8,  149:14, 149:15,  149:18, 150:3  <u>waters</u> [1] - 148:6  <u>ways</u> [2] - 46:11,  112:9  <u>WEBB</u> [1] - 3:11  <u>Webb</u> [1] - 3:12  <u>website</u> [1] - 29:14  <u>week</u> [3] - 45:20, 46:5,  128:22  <u>weekend</u> [2] - 55:13,  78:11  <u>weeks</u> [7] - 42:14,  42:25, 83:6, 152:19,  153:4, 153:5, 153:14  <u>weigh</u> [3] - 91:19,  91:20, 95:2  <u>weighing</u> [1] - 138:2  <u>weight</u> [1] - 151:12  <u>well-developed</u> [1] -  92:13  <u>Werthammer</u> [3] -  24:15, 24:17, 60:16  <u>West</u> [85] - 7:3, 7:4,  12:14, 15:20, 15:25,  16:8, 18:24, 19:1,  19:9, 20:2, 20:3,  20:17, 21:3, 21:23,  22:1, 22:4, 22:5,</p>
	<p><b>V</b>  <u>V.A.</u> [3] - 17:2, 17:16,  36:16  <u>VA</u> [17] - 96:5, 96:7,  96:8, 96:10, 96:12,  96:14, 96:17, 96:20,  97:3, 97:13, 97:15,  97:18, 98:2, 98:4  <u>vague</u> [1] - 103:14</p>			

<p>22:25, 23:2, 23:17, 23:24, 24:3, 24:4, 24:5, 27:21, 29:20, 32:19, 33:1, 33:7, 33:11, 33:16, 33:24, 34:6, 34:9, 34:12, 34:15, 34:19, 34:21, 35:3, 35:6, 35:16, 35:22, 37:13, 37:18, 48:10, 54:18, 57:17, 62:2, 68:12, 69:13, 73:24, 74:16, 81:2, 81:11, 84:8, 84:10, 84:18, 84:21, 84:22, 84:24, 85:13, 85:16, 85:23, 88:15, 88:18, 88:20, 88:22, 89:18, 100:12, 110:14, 110:19, 110:21, 117:8, 117:11, 118:3, 118:5, 123:16, 137:25, 144:4, 148:5, 148:22, 150:18</p> <p><b>WEST</b> [2] - 1:1, 1:18 <b>whatsoever</b> [1] - 38:5 <b>wheeled</b> [1] - 16:5 <b>Wheeling</b> [2] - 12:14, 48:22 <b>whole</b> [1] - 120:9 <b>wholesale</b> [1] - 140:16 <b>wholesaler</b> [4] - 140:8, 140:25, 141:1, 141:12 <b>whoops</b> [1] - 132:18 <b>WICHT</b> [1] - 4:18 <b>Wicht</b> [1] - 30:10 <b>wide</b> [3] - 63:25, 94:3, 108:4 <b>wieldy</b> [1] - 145:15 <b>wife</b> [1] - 148:2 <b>Williams</b> [11] - 4:18, 5:4, 18:9, 32:10, 36:4, 36:8, 59:14, 76:15, 115:4, 130:10, 134:1 <b>window</b> [2] - 126:14, 127:1 <b>wiped</b> [1] - 151:3 <b>witness</b> [15] - 11:8, 11:12, 24:15, 25:2, 26:15, 31:20, 31:22, 31:23, 46:24, 54:10, 76:22, 107:24, 129:12, 150:21 <b>witnesses</b> [14] - 7:11, 7:20, 7:21, 7:22, 7:25, 8:1, 8:9, 13:1, 13:3, 15:8, 24:13, 32:5, 104:11</p>	<p><b>WOELFEL</b> [1] - 3:9 <b>Woelfel</b> [2] - 3:9 <b>woman</b> [1] - 45:18 <b>wonderful</b> [1] - 38:15 <b>word</b> [9] - 7:24, 21:7, 38:3, 53:5, 59:15, 61:22, 139:14, 151:16, 151:18 <b>words</b> [4] - 78:20, 80:3, 86:2, 97:25 <b>work-related</b> [1] - 35:8 <b>Workers'</b> [1] - 35:18 <b>works</b> [2] - 130:24, 153:9 <b>world</b> [2] - 50:16, 127:12 <b>worst</b> [2] - 36:5, 37:21 <b>worth</b> [1] - 59:4 <b>Wright</b> [1] - 42:9 <b>write</b> [8] - 15:5, 22:8, 59:1, 74:14, 78:17, 79:19, 110:5, 130:24 <b>write-ups</b> [1] - 130:24 <b>writes</b> [1] - 109:19 <b>writing</b> [3] - 74:3, 79:21, 143:17 <b>written</b> [13] - 12:9, 14:5, 31:2, 55:18, 56:7, 65:18, 69:10, 69:11, 90:13, 110:5, 141:4, 150:8, 151:14 <b>wrongdoing</b> [8] - 9:7, 72:17, 100:3, 100:25, 101:10, 104:23, 144:17, 144:18 <b>wrongful</b> [3] - 33:19, 81:6, 86:1 <b>wrote</b> [7] - 9:12, 15:6, 20:21, 37:11, 53:7, 60:19, 60:22 <b>WU</b> [1] - 5:10 <b>WV</b> [6] - 2:8, 3:10, 3:13, 4:24, 5:15, 6:9</p>	<p>121:20, 121:22, 121:25, 126:5, 126:17, 132:24, 133:2, 133:3, 133:4, 152:3 <b>yesterday</b> [25] - 10:3, 11:12, 13:5, 13:16, 26:23, 30:4, 30:17, 41:15, 45:25, 51:11, 51:25, 53:10, 55:15, 57:22, 62:1, 66:6, 72:18, 73:5, 82:25, 88:1, 96:2, 116:9, 120:25, 128:3 <b>Yingling</b> [4] - 25:15, 32:7, 36:10, 36:14 <b>York</b> [2] - 3:5, 51:7 <b>Young</b> [1] - 129:1</p>
<b>Z</b>		
<p><b>Zerkle</b> [3] - 114:2, 114:24, 130:3 <b>zero</b> [1] - 74:16 <b>zip</b> [2] - 29:15, 103:2</p>		
<b>Y</b>		
<p><b>year</b> [22] - 9:15, 10:15, 19:9, 20:20, 23:2, 23:24, 28:2, 28:5, 28:24, 34:13, 34:14, 53:22, 53:23, 57:7, 66:9, 86:24, 127:5, 141:23 <b>years</b> [24] - 13:25, 23:16, 25:14, 28:10, 54:5, 61:14, 65:17, 99:1, 99:9, 106:24, 107:4, 109:7, 113:12, 115:17,</p>		